

Understanding Health Across Different Settings: A Nursing Journey

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2. McCarthy J, Holt M (2007) Complexities of policy-driven pre-registration nursing curricula. <i>Nursing Standard</i> . Vol 22 (10) pp35-38.	
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Abstract

Introduction and Background

This thesis presents ten published papers linked by the need to come to a better understanding of health across different settings and contexts. Central to the concept of health is the principle that settings play a pivotal role in shaping positive health outcomes for people and populations. The introduction of the concept of a settings approach to better health is usually attributed to the World Health Organisation (WHO), since its first mention in the Ottawa Charter (1986). I have used the concept of a settings approach (WHO 1986) to understanding health in order to draw the papers in this thesis together.

Helping Nurses Understand Health to Promote Health in Practice.

The idea that nurses are well placed to contribute to positive health in practice settings is well versed within the literature and it is in this context that the first published papers (1-5) and two book chapters are presented. As the publications in this thesis around nursing and its role in promoting health took shape, public health policy drivers from Government and from nursing's professional body continued to emerge (e.g. DoH 1999, 2000, 2004, 2006, 2010, HEE 2015, NMC 2010, RCN, 2012). The papers in this section of the thesis demonstrate the challenge for nurse educators, in particular responding to an ever-changing NHS and the demands and expectations from those we nurse.

Health in University Settings

My work within the UK Healthy Universities Network led to external work for Papers 6 and 7. These focus on student health in universities, and the wider needs of students in such settings. It presents universities as settings for health, which can support students (and staff) using a whole systems approach. This section of the thesis provides the reader with glimpses of how health and, what creates health, is intrinsically linked across different settings and, how nurses can use settings such as universities to explore health and what creates health.

Health in Work Place Settings

Health and wellbeing in the workplace is a concept that is understood as a fundamental business case for a productive, happy, and healthy workforce. The workplace is also a setting by which knowledge and skills about health can be disseminated to assist people, in improving their health and wellbeing. The final paper in this thesis (paper 8), explores the main health and wellbeing needs of a sample of Small and Medium sized Enterprises (SMEs) across Greater Manchester. This work resulted in some unanticipated findings in terms of what creates health for people in SMEs, in particular that of quick fix public health interventions. It provides the reader with, an alternative lens in which to view health and health needs in the workplace.

Summary

The papers within this thesis and the contribution of the work that enabled their development, is intrinsically linked by the ideology of settings as places where people experience health and, what creates health for them in those settings. Being a nurse is at the heart of this thesis, it is where it begins, and this is where the thesis returns to at the end. Within this thesis, I have explored health in different settings through a research lens. From this, I am able to propose that by taking a settings approach to understanding health through the undergraduate nursing curriculum, alongside the use of non-traditional settings (e.g. universities and workplaces) for student nursing placements, nurses may then truly understand health and what creates health, for those they work with and care for. The papers, and subsequent work that has resulted from them, have enabled me to be at the cutting edge of nurse education. I have represented these within the thesis as a timeline linked to how these changes influenced my work and, my contribution to nurse education, workplace health, and health within universities.

Acknowledgements

I am indebted to Professor Duncan Mitchell for his patience and understanding. He helped create the 'aha' experience during the most difficult times when writing this thesis. Thank you to Professor Susan Powell for her grounding when things got tough and for the opportunities, you created for me in public health research. I wish to thank my family for their continuous patience and support throughout the journey. I dedicate this thesis to my Dad who unfortunately was taken away from us, before he could witness the end of this journey.

Chapter 1: Introduction

The purpose of this thesis is to discuss a collection of published work for which I am author or co-author. Using a reflective conversational style throughout, it seeks to demonstrate the variety of ways in which people experience health and what creates health for them, across the different settings of their everyday lives. The published works within the thesis and the research or project that contributed to them, lead me to propose that, taking a settings approach to understanding health within the nursing curricula and the use of non-traditional placements, may help nurses better understand health and the health needs and expectations of the people they care for and work with. It is driven by the overwhelming nursing literature championing nurses as health promoters, my work in the classroom setting and my own research in nursing and other settings. This forms my overall contribution to the existing body of knowledge. However, whilst I offer this argument as a sum of my thesis my contributions have been far more reaching than the conclusion I have come to. This thesis demonstrates a professional and academic journey and my contributions to knowledge have been accumulative as my journey progressed. I have therefore depicted the sum of my contributions diagrammatically as a time line at the end of this chapter (Figure 1) as each project and subsequent paper lead to other involvements nationally and internationally. The style of this thesis is then, that of a parallel learning journey. By using a story approach as method it brings together, my own published work around my contributions to helping people to understand health, in their own worlds and contexts. Over the years, I have found that it is personal stories that have had the most potential for impact on individual practice because; nurses seem to give their attention to stories more than other media. It is through story that we are able to explore the sphere of nursing that makes sense of our endeavor to create meaning for our patients and ourselves. As Ellis (2004 p178) proposes:

We may not have to have a reason to tell a story, but we ought to have a reason to publish it.

The published work within this thesis forms a collection of work that has occurred over a number of years. I was finding my way in academia in those early days and had no intention at that stage, of undertaking a PhD by publication. As my roles within my organisation changed and took me down different avenues, I began to publish more work and from these could see a pattern forming. Despite the fact that my later published work became stronger in terms of data related research papers, they and the earlier work were all intertwined by the need as a nurse, to understand and promote health. This long apprenticeship has meant that the direction of my research into better understanding health for nursing practice has, emerged from experience and familiarity. This journey approach has enabled me to distinguish a true intellectual focus from that of simply ephemeral passing interest. This has meant that I have never lost interest in my own research.

The literature continues to provide us with an array of definitions of *health*, its different labels and ideologies. I will argue that these definitions can, for nurses, be somewhat confusing, and as a result fail to be utilised in practice, are not often consistent with lay people's understanding of health (Katze et al 2002, Tones and Green 2004) or, their experiences of health in different contexts. It is this argument that forms the context for this thesis. Therefore, this thesis does not aim to offer a single definition of health but to recognise and support the contentions and debates around the term.

Methodology

The exploratory nature of this thesis, along with the focus on human factors, and experiences such as those that create health for people, led to the selection of qualitative research methods for the papers and the projects from which they came. I am a qualitative researcher and found Patton's (2002) text on qualitative research and evaluation methods, to be a bible for me in the early days of my research. It helped me to understand qualitative methods and all the aspects that they involved. The qualitative methods across the papers include focus groups, questionnaires, surveys, and student reflections. I adopted a thematic analysis approach across all papers, which was, in my early work, guided by that from Braun and Clarke (2006). This form of analysis is often used in the social sciences to identify patterns or trends in the

form of themes (Flick, 2006; Braun and Clarke, 2006). In my later work around Healthy Universities, I had the responsibility of supervising an intern new to qualitative research and working with me on the research for paper 7. I was at that time introduced to the work of Attride Sterling (2001) using thematic networks. She describes her framework as a simple way of organising a thematic analysis of qualitative data, a “web like network as an organising principle” (Attride Sterling 2001 p383). I found her work to be a useful framework for adaptation to meet the requirements of the work we did in paper 7. In addition, her framework was very useful for me in guiding and supporting a new researcher. I presented the use of Thematic Networks as a means of organising qualitative research, at the September 2015 NHS Northwest Research and Development Conference, “Let’s Talk about Research”.

The Structure of the Thesis

The thesis is presented as a body of work and structured thematically, drawing on the connections between the different papers. It can be read in any manner; however, the most reader friendly approach may be to read the papers before the thematic commentaries. The papers are not presented in chronological order but are organised in themes. The published works in this thesis include a mixture of formats. These include position papers in terms of nursing and the promotion of health, practice led nursing knowledge book chapters, and data led research papers. All are significant in the development of the thesis.

Chapter 4 of the thesis includes published works that were submitted at the application stage of the PhD by publication process. The rationale for using the earlier work is that it is fundamental to the development of the whole thesis, as indeed this is where my journey to understanding health across different settings began. The attached citation record of these earlier publications also indicates that they continue to be cited both nationally and internationally. The commentaries in each chapter will direct the reader back to the specific paper(s) in that chapter. Where the published papers have been cited by others, and this occurs predominantly in the earlier published work in Chapter 4, such citations will be drawn upon to further the

discussion commentary. The final chapter will draw upon the connection between the papers and will reflect upon the main learning points for me and for future research.

I have used the concept of a settings approach (WHO 1986) to understanding health in order to draw the papers together. Each setting represents a new area of my professional work and subsequent publications. My academic journey began as a senior lecturer in nursing where I campaigned to put health and in particular the promotion of health, at the core of undergraduate nursing education and practice. The rationale behind this is that nurses work across different settings and therefore are in a unique position to help people understand health. My work within nursing and curriculum development led to me becoming a Principal Lecturer in Public Health, focusing on health across community settings, both internal and external to the university. As I became more experienced in research and more recognised in terms of my work, my journey took me to commissioned research into other settings such as social care, workplaces and communities. The thesis presents published papers from my journey across these different settings. The overall structure of the thesis is as follows:

Chapter 1: Introduction.

Introduces the thesis and describes the different published papers and, overall structure of the thesis. It provides a table of my published work and where relevant, their citations and journal impact factor.

Chapter 2: Where It All Began.

Provides a narrative of where my ideas originated from, my motivation and influences. It provides a background to my professional role as a nurse and subsequently a nurse lecturer/researcher that has led to the papers presented in this thesis.

Chapter 3: Understanding Health in Different Settings.

The concept of settings for health is used as a framework for drawing the published papers within this thesis together. Drawing upon the literature, this chapter provides

an overview of the concepts of settings and its relationship to each of the papers.

Chapter 4: Helping Nurses to Understand Health to Promote Health in Practice

It is in this chapter that published papers 1-5 and two book chapters will be presented alongside a commentary and critique. The chapter draws on supporting literature around nursing and its contribution to helping people understand health and the promotion of health within the wider context of public health.

Chapter 5: Helping People Understand Health in Universities

As I moved into a new role as Principal Lecturer in Public Health, I became involved in wider health issues and commissioned projects. This chapter draws further upon the ideology of settings as a means of exploring and understanding health. Papers 6 and 7 focus on health in universities which is gathering momentum at national and global levels. These papers are presented alongside a commentary and supporting literature.

Chapter 6: Helping People Understand Health in the Workplace

My research and commissioned projects were beginning to take me into new settings of research in order to understand health. Health and wellbeing in the workplace is a concept that is understood as a fundamental business case for a productive, happy and healthy workforce. The workplace is also a setting by which knowledge and skills about health can be disseminated to assist people in improving their health and wellbeing. This chapter presents paper 8 and the final paper in this thesis, which explored the main health and wellbeing needs of a sample of Small and Medium sized Enterprises (SMEs) across Greater Manchester.

Chapter 7: Reflections and Conclusions

This chapter draws my conclusions together as I return to my roots as a nurse, as this is where it all began. This thesis has presented eight published papers and two book chapters as a collection of work linked by the need to come to a better understanding of health across different settings and contexts. The collection of work in this thesis has presented me with greater insight into the variations between health, and peoples own perceptions of health. Such insight offers those of us involved in the

development of nursing curricula to deconstruct some of its ideologies and consider alternative ways of understanding health and helping nurses understand health.

The published works presented in this thesis are wide ranging in their format. They have and continue to be, cited by other authors both internationally and nationally. They have contributed to existing evidence and informed new practice, in areas such as working with central government in developing public health nursing competencies, workplace health initiatives and student health in universities. The findings and contents of the published works have been shared through practitioner publications, national and international conferences, presentations, reports, meetings and classroom teaching. My professional roots as a nurse have always been at the heart of this thesis despite diversifying my roles over the past few years. The thesis has demonstrated how nurses can diversify their practice and continue to work with people to understand and improve health across different settings.

Figure 1: My Journey Timeline and My Contributions to Knowledge

Paper	1 2007	2 2007	3 2008	4 2008	5 2011	Book Chapters 2011	6 2012	8 2014	7 2015
Policy Drivers	DoH (1999) WHO (2000) DoH (2004) DoH (2006)	DoH (1999) WHO(2000) DoH(2004) DoH (2006)	DoH (1999) WHO(2000) DoH(2004) DoH (2006)	DoH (1999) WHO(2000) DoH(2004) DoH (2006)	DOH (2010,2011) RCN (2011, 2012)	NMC (2010) RCN (2011, 2012) HEE Willis Report (2015)	DOH (2011) RCN (2011, 2012)	Black (2008) Boorman (2009)	UK Healthy Universities (HU) network (2010) DoH (2008) Okanagan Charter (2015)
Personal Contribution	Curriculum development in my own organisation and contribution to Institutional NMC Nursing programme revalidation.	Presentation at UKPHA conference	International conference presentation in Netherlands	Editor invitation to write this short position paper for journal.	Invited to contribute to a working group for Central Government on developing public health competencies across all nursing. Invitation to write subsequent book chapters Presentation at the NET/NEP conference in Sydney.	Contribution to the wider field of nurse education. Completed MPhil Invitation to HEE (NW) to develop a framework for best practice for public health content of undergraduate health curriculum (2015)	Contribution to understanding the needs of students and staff in HEIs for gambling related health issues. Contribution to the UK Healthy Universities Network evidence base.	Contribution to the limited research into Health and wellbeing in SMEs. Further Commissioned work Presentation at the 2 nd International wellbeing at work conference	Invited to represent the UK HU network on the NW regional wellbeing board for HEI staff wellbeing. 3 paper presentation at the International Health Promoting Universities Conference Vancouver. Study to review the UK HU self-Review Toolkit across HEIs Presentation at NW R&D conference Working group to review the Edmonton Charter and to develop the new Okanagan Charter (Oct 2015)

Published Articles and Citations

Title	Citations	Impact Factor
<p>Paper 1 Holt M, Warne T (2007) The educational and practice tensions in preparing pre-registration nurses to become future health promoters: a small scale explorative study. <i>Nurse Education in Practice</i>. Vol 7 (6) pp 373-380.</p>	<p>Figueiredo MC, Amendoeira J (2015) Health Promotion in Nursing Curricula: The knowledge of teachers and the meanings attributed by students - systematic literature review <i>Think Nursing</i> Vol. 18 No. 2. Portugal.</p> <p>Ekelund K, Stahl, A (2012) If you see someone who is on his way out of a cliff so if you want to prevent the "-Distriktssköterskans view of the work to promote health. University of Borås / School of Health Science.</p> <p>Healy D, McSharry P (2011) Promoting self-awareness in undergraduate nursing students in relation to their health status and personal behaviours. <i>Nurse Education in Practice</i>. Vol 11(4) pp228-233.</p> <p>Holt M (2008) The educational preparation of student nurses as communicators of health and wellbeing. Perspectives in Public Health. <i>Journal for the Royal Society in Public Health</i> Vol 128 (4) pp159-160.</p> <p>Holt M (2011) Public health and nursing practice: Seizing the receptive moment. <i>Nurse Education in Practice</i>. Vol 11 (4) pp224-227.</p> <p>Jarvis L, Roden J (2012) Evaluation of the health promotion activities of paediatric nurses: is the Ottawa Charter for Health Promotion a useful framework? <i>Contemporary Nurse</i>. Vol 41 (2) pp271-284.</p> <p>Johnstone J H (2009)The preparation of child health nurses in sexual health education: An exploratory study. <i>Nurse Education Today</i>. Vol 29 (8) pp845-849.</p>	<p>Unknown</p> <p>Unpublished Thesis</p> <p>1.456</p> <p>1.035</p> <p>1.218</p> <p>1.217</p> <p>1.456</p>

	<p>Mooney B, Timmins F, Byrne G, Corroon A M (2001) Nursing students' attitudes to health promotion to: Implications for teaching practice. <i>Nurse Education Today</i>. Vol 31 (8) pp841-848,</p>	1.456
	<p>Piper S (2009) Health promotion for nurses: theory and practice. Routledge Oxon.</p>	Unknown
	<p>Roden J, Jarvis L, Campbell-Crofts S, Whitehead D (2015) Australian rural, remote and urban community nurses' health promotion role and function. <i>Health Promotion International</i>, April 2015 pp1–11.</p>	1.035
	<p>Schofield R, Ganann R, Brookes S, McGugan J, Kim Dalla Bona K, Betker C, Dilworth K, Parton L, Reid-Haughian CR, Slepko M, Cori Watson C (2011) Community Health Nursing Vision for 2020 Shaping the Future. <i>Western Journal of Nursing Research</i>. vol 33 (8) pp1047-1068. Sage Canada.</p>	2.125
	<p>Scott S (2011) A tripartite learning partnership in health promotion. <i>Journal of Nursing Praxis</i> 27(2):pp16-23. New Zealand.</p>	1.316
	<p>Valaitis R K, Rajsic C J, Cohen B, Leeseberg Stamler L, Donna Meagher-Stewart D, Froude S A (2008) Preparing the Community Health Nursing Workforce: Internal and External Enablers and Challenges Influencing Undergraduate Nursing Programs in Canada. <i>International Journal of Nursing Education Scholarship</i>. Vol 5, (1), pp1–21,</p>	2.075
	<p>Varley L, MacNamara C, Mannix-McNamara C (2012) Preceptorship: exploring the experiences of final year student nurses in an acute hospital setting. <i>Journal of Hospital Administration</i>, Vol1 (2) pp42-53.</p>	2.125
	<p>Walthew P, Scott H (2012) Conceptions of health promotion held by pre-registration student nurses in four schools of nursing in New Zealand. <i>Nurse Education Today</i>. Vol 32 (3) pp239-234.</p>	1.456

	Wand T (2011) Real mental health promotion requires a reorientation of nursing education, practice and research. <i>Journal of Psychiatric and Mental Health Nursing</i> . Vol 18 (2) pp131–138. Australia.	1.456
	Whitehead D (2008) An international Delphi study examining health promotion and health education in nursing practice, education and policy. <i>Journal of Clinical Nursing</i> . Vol 17, (7) pp891–900. New Zealand.	2.125
	Whitehead D (2009) Reconciling the differences between health promotion in nursing and ‘general’ health promotion. <i>International Journal of Nursing Studies</i> . Vol 46 (6) pp 865-874. New Zealand.	1.377
	Whitehead D (2011) Health promotion in nursing: a Derridean discourse analysis. <i>Health Promotion International</i> . vol 26 (1) pp117-127. New Zealand.	1.316
	Whitehead D (2011) Before the cradle and beyond the grave: a lifespan/settings-based framework for health promotion. <i>Journal of Clinical Nursing</i> . Vol 20 pp2183–2194. New Zealand.	1.038
	Whitehead D, Irvine F (2011) Ottawa 25+—‘All aboard the Dazzling Bandwagon’—developing personal skills: what remains for the future?. <i>Health Promotion International</i> , Vol. 26 (2)	1.233
	Willshire K A (2010) Overcoming mixed messages on alcohol consumption: A teaching strategy. <i>Nurse Education in Practice</i> . Vol 10 (5) pp 279-284. South Australia.	1.035

<p>Paper 2</p> <p>McCarthy J, Holt M (2007) Complexities of policy-driven pre-registration nursing curricula. <i>Nursing Standard</i>. Vol 22 (10) pp35-38.</p>	<p>Baran S W, Johnson E J, Kehler J, F, Hankenson C (2010) Development and Implementation of Multimedia Content for an Electronic Learning Course on Rodent Surgery. <i>Journal of the American Association for Laboratory Animal Science</i>. Vol 49 (3) pp307-311</p> <p>Holt M (2008) The educational preparation of student nurses as communicators of health and wellbeing. Perspectives in Public Health. <i>Journal for the Royal Society in Public Health</i> Vol 128 (4) pp159-160.</p> <p>Holt M (2012) Public health and nursing practice: Seizing the receptive moment. <i>Nurse Education In Practice</i>. Vol 11 (4) pp224-227.</p> <p>Odessa P D D (2011) Exploring e-learning adoption in nurse education: A socio-cultural case study using Q and Bourdieu. University of Nottingham.</p> <p>Little M C (2013) An exploration of children's nursing graduates' ability to assess children's emotional health and well-being. <i>Journal of Child Health Care</i>. pp1-11. Sage Publications.</p> <p>McCarthy J (2014) Implications of online learning for nurse managers. <i>Nursing Management</i>. 21, 7, pp23-27</p>	<p>0.731</p> <p>1.218</p> <p>1.218</p> <p>Unknown</p> <p>1.142</p> <p>1.142</p>

<p>Paper 3</p> <p>Jack K and Holt M (2008) Community profiling as part of a health needs assessment. <i>Nursing Standard</i>. Vol 22 (18) pp51-56</p>	<p>Barnes S (2015) Benefits of opportunistic cervical screening at a sexual health clinic. <i>Primary Health Care</i>. 25, 4, 18-22.</p> <p>Bennett C, Perry J, Lawrence Z (2009) Promoting health in primary care <i>Nursing Standard</i>, 23(47):48-56</p> <p>Gonçalves C, Ramos V, Colaboração, Cerqueira M (2010) <i>CIDADANIA e SAÚDE Um caminho a percorrer... Escola Nacional de Saúde Pública/ UNL</i></p> <p>Guzys D (2013) "Community needs assessment." An Introduction to Community and Primary Health Care in Australia. Cambridge University Press.</p> <p>Micallef C (2014) Community Development as a Possible Approach for the Management of Diabetes Mellitus Focusing on Physical Activity Lifestyle Changes: A Model Proposed for Maltese People with Diabetes. <i>International Journal of Community Development</i> Vol. 2, No. 2, 2014, pp30-40</p> <p>Sakellari E (2012) Assessment of health needs; the health visiting contribution to public health. <i>International Journal of Caring Sciences</i>. Vol 5 (1) pp19-25.</p> <p>Tinnon V I (2010) Environmental Injustice: Health and Inequality in Mobile County, Alabama. Kansas State University Manhattan, Kansas</p> <p>Sinay T, Acosta-Deprez V, PhD Erlyana E (2014) Health Needs Assessment In Inner Cities: Does ZIP code Analysis Reveal Better Results? <i>Journal of Health Care Finance</i>. http://www.healthfinancejournal.com/</p>	<p>Unknown</p> <p>0.932</p> <p>Unknown</p> <p>0.360</p> <p>0.920</p> <p>1.162</p> <p>Unknown</p> <p>0.710</p>

<p>Paper 4</p> <p>Holt M (2008) The educational preparation of student nurses as communicators of health and wellbeing. Perspectives in Public Health. <i>Journal for the Royal Society in Public Health</i> Vol 128 (4) pp159-160.</p>	<p>Blake H, Harrison, C (2012) Health behaviours and attitudes towards being role models. <i>British Journal of Nursing</i> Vol 22 , No 2 pp 86–94</p> <p>Choi W H, Gabriel K.H. Hui G K H, Lee A CK, Chui M L (2010) Student nurses’ experiences and challenges in providing health education in Hong Kong. <i>Nurse Education Today</i>. Vol 30 (4) pp 355-359.</p> <p>Holt M (2012) Public health and nursing practice: Seizing the receptive moment. <i>Nurse Education In Practice</i>. Vol 11 (4) pp224-227.</p>	<p>Not Known</p> <p>1.456</p> <p>4.456</p>
<p>Book Chapter</p> <p>Holt M, Webb L (2011) ‘Engagement, motivation, and changing behaviour’ <i>Nursing: Communication Skills in Practice</i>. Oxford University Press</p>	<p>Roberts D, Holland K (2013) <i>Nursing: Decision Making for Practice</i>. Oxford University Press.</p>	<p>Unknown</p>
<p>Book Chapter</p> <p>Holt M (2011) "Health promotion and communication techniques." <i>Nursing: Communication Skills in Practice</i>. Oxford University Press</p>		<p>Unknown</p>
<p>Paper 5</p> <p>Holt M (2011) Public health and nursing practice: Seizing the receptive moment. <i>Nurse Education In Practice</i>. Vol 11 (4) pp224-227</p>	<p>Boozary A, Dugani S B (2011) Institute of Social Justice and Medicine: Developing a think tank to promote policy formation. <i>Clinical and Investigative Medicine</i>. Vol 34 (5) pp259-261</p>	<p>1.15</p>

<p>Paper 6 Holt M (2012) The debt crisis: Tackling gambling related harm to students in higher education. <i>Health and Social Care Education</i>. Vol 1(1) pp14-16.</p>		
<p>Paper 7 Holt M, Monk R, Powell S, Dooris M (2015) Student Perceptions of a Healthy University. <i>Health Education</i> (in Press)</p>		
<p>Paper 8 Holt M, Powell S (2014) Health and wellbeing in small medium enterprises (SME). What public health support do SMEs really need? <i>Perspectives in Public Health. Journal for the Royal Society in Public Health</i>.</p>	<p>Hartwell H (2105) Mental Health and Wellbeing. <i>Perspectives in Public Health. Journal for the Royal Society in Public Health</i>. Vol 135 No 1.</p>	<p>1.218</p>

Chapter 2: Where it all began

My ‘call to the adventure’ of Post-Graduate Study

As an analytical and reflective piece of work, it is important that I describe where my ideas originated, what experiences informed these decisions and my own background. This will support the reader in appreciating the context within which the thesis took shape. I am a Principal Lecturer in Public Health working in a large university. My current role is to develop the many facets of public health practice across the university. This work involves a curriculum development and advisory role, undertaking commissioned projects, research and consultancy work. In addition, I am a qualified nurse with over 30 years of experience across general nursing, with a particular focus on community and practice nursing.

The idea and motivation for putting together this thesis began quite some time ago in the lecture theatre and classroom, when as a Senior Lecturer in Nursing, I was teaching undergraduate student nurses studying the adult branch of general nursing. My teaching topic was health and promoting good health. As a faculty we were, at the time, implementing curricular changes to assist the students in learning about health. In summary, such changes involved helping the students to learn about health, its’ enabling and disabling influences and how to promote good health. This put health at the very heart of the curriculum and was something that I instinctively embraced. However, this was, at times at odds with our student nurses and some of my academic colleagues. Their image of nursing being, that they were there to cure and care for the sick and this view at times was difficult to change. Significantly, some nurse managers within practice settings also shared this view as they sought newly qualified nurses who they considered able to work competently in the clinical setting as clinical nurses.

In coming to this PhD I, like many other postgraduate researchers, considered myself to be on a journey or as Lather (1986) proposed, a ‘call to the adventure.’ of postgraduate study. The published work within this thesis forms a collection of work that has occurred over a number of years. During this time, my academic role has changed and these changes are quite significant in terms of the work I now do, as a

Principal Lecturer in Public Health. They are also significant in terms of personal and academic growth and development. In presenting this thesis, I have expressed the contents in two voices: the academic voice of inquiry and argument within my published work and the voice of reflexive narrative. This reflexivity enables me to consider how working with people to understand health in different contexts and settings has shaped my own thinking as a nurse and lecturer. The concept of reflexivity is one that is increasing in popularity amongst nurse researchers, who are encouraged to understand themselves and think about their own thinking.

First and Foremost a Nurse

I am smiling somewhat wryly at the above heading, as this concept is one that has returned to me on a number of occasions, as I develop myself as a researcher and in putting this thesis together. Quite some time ago, for some previous work, I was required to consider and write down what nursing is to me. It is an important question and one, which we ask all applicants to consider prior to interview for a place on the BSc (Hons) Nursing programme within our university. Their responses elicit a variety of perceptions of nursing that predominantly focus around the desire to care, treat, cure, and apply exciting clinical and technological interventions often depicted in nursing TV programmes.

When I was asked to consider this question myself, I found a very old photograph of me taken in my first months as a student nurse and thought about what memories, images and representation about nursing it conjured within me. Where have I come from and who am I now?

Taylor (1989 p47) suggests that:

Making sense of one's life as a story is also, like orientation to the good, not an optional extra. ... In order to have a sense of who we are, we have to have a notion of how we have become, and of where we are going.

The academic process of becoming a nurse demonstrates that a person has attained the required knowledge skills and competencies to practice. However, becoming a nurse is much more than this; it is a social process, which involves learning about its culture, customs and meaning. This is a concept, which is found in many of the

nursing theories or philosophies inherent in nursing for example Benner (1996). Others such as Peate (2006) on *Becoming a Nurse in the 21st Century* continue to draw upon traditional theorists such as Benner (1996) and Henderson (1960) to illustrate modern nursing. The difficulty lies in that our familiarity with the nursing profession as we become experienced nurses, may make us begin to take for granted what has and does, shape us to become nurses. I want to begin this thesis by revisiting where I have come from and who I am now. I will do this by drawing upon extracts from my early narratives about what nursing means to me, as I present a background to my nursing career thus far, and how I got to this point.

Nightingale (1859 p8) proposed that the:

Very elements of nursing are all but unknown' and that Nature alone cures... and what nursing has to do... is to put the patient in the best condition for nature to act upon him.

Since her pedagogical and epistemological perspectives were delineated, debates around definitions of nursing have continued. Nightingale saw health and healing as distinct from the cure of illness. She espoused that nursing was separate from medicine and that nursing was in fact an activity that would promote health in any care giving circumstance (Nightingale 1859). The latter resonates with the work within this thesis, contemporary nursing literature, Government, and nursing policy around the role of nurses in promoting health (for example DoH 1999, 2006, HEE Willis 2015, RCN 2012). However, Nightingale (1891) did not define health specifically and whilst it is recognised that the healthy environment that she espoused is conducive to health, one must question the applicability of that today given the environmental conditions we now face. It may then seem then that her model of nursing is ideal. Notwithstanding this, the Nightingale model of nursing did believe that disease was a literal concept, which was the absence of comfort and that the environmental paradigm was important in improving conditions for health. These concepts sit well within this thesis when exploring health in paper 8 and the work on Healthy Universities in paper 7. They also resonate in particular with the salutogenic concept of settings to promote health (Antonovsky 1996, Dooris 2004). Based on my many years of professional nursing experience, I have found *health* to be a significant

value in people's lives. So what thoughts and memories did my old photo invoke in me about nursing and health?

My entry to the nursing profession was not due to any calling or ambition and I did not actually begin my training until 3 years after leaving compulsory education. I was not a high academic achiever at school but wanted a career. Nursing seemed to be one, which suited my vocational skills rather than my academic skills. My initial nurse-training programme in the 1970s followed the apprenticeship model attached to schools of nursing, which were integrated into the hospital system. As salaried members of the workforce and part of the team - we did the job. As student nurses we were prepared for practical bedside hospital care and this was very much reflected in the nurse curriculum. The wards were Nightingale wards and nurses seemed to have time to really chat to patients and learn about them as people. When I look at the photograph of me at the beginning of my training, I remember not only the idealism, but also conversations with patients, which helped to form my ideas of the nature of illness and health.

I recall two people who had a significant influence on me as a nurse throughout my nurse education; both were nurse tutors. The first tutor was during my initial nurse training in the mid-1970s when the photo I had found was taken. She was a clinical tutor and I perceived her role as one, which was fundamental in applying nursing theory to practice. She taught and assessed students in both the classroom and the ward setting. As students, we felt that the clinical tutor was our advocate, a knowledgeable nurse who came onto the wards to observe, assess, support and when required, reprimand us as students. Clinical Tutors to me were nurses who did the job they taught, and because of this, were respected by all. I vividly recollect my clinical tutor as a no-nonsense person, who appeared to care genuinely about each of the patients she met. She was my role model and someone I wanted to be.

Nursing, to me is first about caring; a concept well examined within the nursing literature (for example Khademian and Vizesfar 2007, Leininger 1984). A wealth of philosophical suggestions for interpretations of caring exist and this is not the purpose of this thesis. My concept of care is having the ability to care for people and about people within a professional context. Caring 'for' people as a nurse is about aspects

of caring which are learned during the attainment of the required technical competencies. This is the person I recall when I look at my old photo taken at the start of my training, wearing a student uniform to indicate ones position in this required learning process.

Caring ‘about’ people for me, is different and is about building trust, having respect for, being interested in a person’s health, of genuineness and compassion. This idea of genuineness originates from the work of humanists such as Rogers (1967) and his suggestion that the therapist is ‘transparently real’. For me, it is more about being able to personalise care to suit the individual and to recognise that the ways in which a nurse expresses caring, develop and change. Aranda and Street (1999) and their work on care best describes my articulation. They examined the value that nurses placed on what they called genuine relationships with patients using the term ‘authenticity’, (Aranda and Street 1999 p78). The caring objective was demonstrated by a nurses’ ability to adapt to patients individual needs by changing their approach to suit the patient. They likened this to being a chameleon and this analogy captured for me the very nature of what nurses do, or should do. We change and adapt to suit the needs and situation of the patient. This idea of genuiness is not the same as that discussed by Andersson and Edberg (2010) who describe the transition of being a ‘rookie nurse’ to becoming a ‘genuine nurse’ as one where the nurse becomes an accepted member of the nursing team and is able to shoulder responsibility, prioritise tasks, and convey confidence to patients. The idea of authenticity as suggested by Aranda and Street (1999) has guided my practice to understand that care is not just about going through the motions of providing physical care. It is about genuinely having an interest in the patients’ health and wellbeing and wanting the patient to achieve good health. On reflection, this idea probably guided me as a nurse towards working in clinical areas where I found it easier to do this, for example in General Practice. Given the content and themes of the early papers and nursing practice within this thesis, I realise that there is some incongruence here in that within these papers I am arguing that all nurses across all settings should and can, promote good health. This idea of authenticity and wanting to help patients discover the possibilities of attaining the best health they can, guided me towards nurse education where I felt I could influence nursing practice through classroom teaching. Seabold and Carraro (2013 p26) sum this up for me:

However, it can be observed that these teaching professionals are not only involved with the care practice, but also with those they teach the care practice to, thus developing a career with the other and intending to provide the students with several ways and opportunities in their learning processes. For that purpose, they engage in a unique preparation process in order to share their experiences with their students.

Care within the professional nursing relationship, provides a fundamental context for empowerment (Falk-Rafael 2001). It is a necessary component for empowering people to attain health. To contextualise this within this thesis, such a caring approach empowers and enhances patients' ability to understand and make choices about their health. Despite this, a study of health promotion activities by nurses suggests, that whilst empowerment was one of the most important theoretical bases for health promotion activities by nurses, it is not embedded in health promotion activities in practice (Kemppainen et al 2012).

In 1891, Florence Nightingale stated:

I look forward to the day when there will be no nurses of the sick, only nurses of the well.

I do appreciate that my own thoughts and beliefs may resonate with nostalgia but they do hold with Nightingale's contemporary understanding of health and sickness. Her quote above is probably the most significant one within this thesis as it gets to the very core of what I am trying to represent throughout this thesis. That nursing is more than just sickness nursing and that nursing practice should work to prevent disease, caring for well patients as well as caring for sick patients. The most important job of a nurse is to ensure that the patient is empowered to understand and achieve their optimal health.

The second tutor who influenced me as a nurse was in 1990, as I undertook further nurse education from State Enrolled Nurse (SEN) to Registered General Nurse (RGN). Nursing had moved towards higher education and academia. My tutor for this period of my nurse education emphasised the academic nature of nursing; he was passionate about the relationship between theory and practice. He questioned nursing practice from my original training and challenged us to consider why we did things the way we did, how research contributed to nursing and what contribution we could

make. I became hooked on theory and its relationship to nursing. This phase in my nurse education was so different from my initial training; just like Julie Walters portrayed in the film *Educating Rita*. I became educated!

During my gaze through the literature on caring and nursing, I came across Mayeroff (1971) and Swanson (1991) and their proposition of a table of major ingredients required for caring. Whilst somewhat dated, their work is still referred to in contemporary books and journals when discussing the theoretical issues of caring. As their first ingredient, both list that of 'knowing'. Mayeroff (1971 p19) proposes that:

To care for someone, I must know many things. I must know, for example, who the other is, what his (sic) powers and limitations are, what his needs are, and what is conducive to his growth; I must know how to respond to his needs and what my own powers and limitations are.

Rose (2008 p45) helps me clarify further what nursing is to me in that the caring nurse will be:

An educated nurse who keeps up to date with changes and developments in practice.

My addition to such a list would be that it is also about retaining its values. These attitudes do not come automatically as Scott (2013) suggests, nurses must be educated and supported to develop the virtues that underlie the practice of caring.

The last 10 years of my nursing practice was spent in the community as a Practice Nurse in a rural GP practice, where I became interested in health promotion and preventative health. This was in the halcyon pre fund-holding days when nurses had time to spend with patients discussing their lives, their health, and the factors that influenced it. 3 years of this time was spent in a busy single-handed GP inner city practice where I learned more about health and its influences, than I had in my entire career so far. I witnessed the effects of poor health and the influences that poverty, education and culture could have on health and the understanding of health amongst the patients and community. This was health in their contexts and the experience was to me invaluable. As time went by, and fund-holding policy came into General

Practice, I felt that I became less of a nurse in the constant effort to meet financial targets. I became frustrated and subsequently left practice to take up a full time teaching post. I have been teaching now for the past twenty years with a predominant focus on health, health promotion and public health and these forms the context of the first published works within this thesis. Two years ago, I became a Principal Lecturer in Public Health. Despite the title of Lecturer, this role has taken me away from the classroom and lecture setting to more research and commissioned project work under the umbrella of public health. This has been a significant side step from my traditional role as nurse, nurse lecturer and has taken me to areas of work that I would never have anticipated. It is in this role that I have published the later work within this thesis.

Summary

My intention, in using personal narratives and reflections has been to provide glimpses or snapshots into my professional life thus far. This current post-graduate journey has not arisen from a theoretical question, rather it is driven by my practice as a nurse, and where this has led me to date. Revisiting my career thus far and my previous memories about nursing has been somewhat cathartic. There are some however, who may find such an approach to be that of a 'confessional tale' (Van Maanen 1988). Nevertheless, I feel such self-dialogue and discoveries are a valuable and exciting part of my research journey to be documented as such. The following chapters present a collection of published work and supporting commentaries as I come to understand more about health for people indifferent contexts and settings.

Chapter 3: Understanding Health in Different Settings

The concept of the settings approach to health owes its origins to the Ottawa Charter (1986):

Health is created and lived by people within the settings of their everyday life; where they learn work, play and love (Ottawa Charter 1986).

The mid 1980s saw a transformation from a biomedical model of health to that of a socio-ecological paradigm, which recognised the intrinsic link between health and the environment. This reflected the emerging view of the:

Interdependence between human beings, their health and their physical and social environments (Kickbush 1989 p265).

Central to the concept of health is the principle that settings play a pivotal role in shaping positive health outcomes for people and populations. Settings do this by exposing individuals to health practices within a variety of social systems, which enable people to develop skills, knowledge, attitude and behaviours to health. We are, over the lifespan, exposed to numerous social systems, which provide an influence on health outcomes. These social systems have their own unique culture and systems but all are interconnected.

The introduction of the concept of a settings approach to better health is usually attributed to the World Health Organisation (WHO), since its first mention in the Ottawa Charter (1986). The concept of understanding health and its influences across settings has appeal for a number of reasons. Health is created and influenced by a place or social context in which people engage in their daily lives; a place where environmental, organisational, and personal factors interact to affect health and well-being. A setting is where people actively use and shape the environment and thus create or solve problems relating to health (Dooris 2004). Therefore, a settings approach to understanding health encourages consideration of what actually impacts upon a person's health. Understanding health within a settings framework recognises

that people do not just live or interact within one setting. Figure 2 demonstrates different settings that can touch people's lives and how their lives may straddle a range of different settings, similar to that of Russian dolls. These settings can be experienced either concurrently or consecutively and at multiple levels, for example a home or school, is part of a community or neighbourhood. The concept of the settings approach to health reinforces the need for a joined up approach between the various settings and at every level, to enable positive health outcomes. The rationale for adopting a settings approach to understanding health is that it addresses a range of physical, social, organisational, and cultural factors, influencing health in an environment. Settings as an underpinning framework for understanding health is then, more than just a convenient means of reaching target groups; they are social systems which support health and provide opportunities for changing social systems and not just individuals (King 1998, Paton 2005, Golden and Earp 2012).

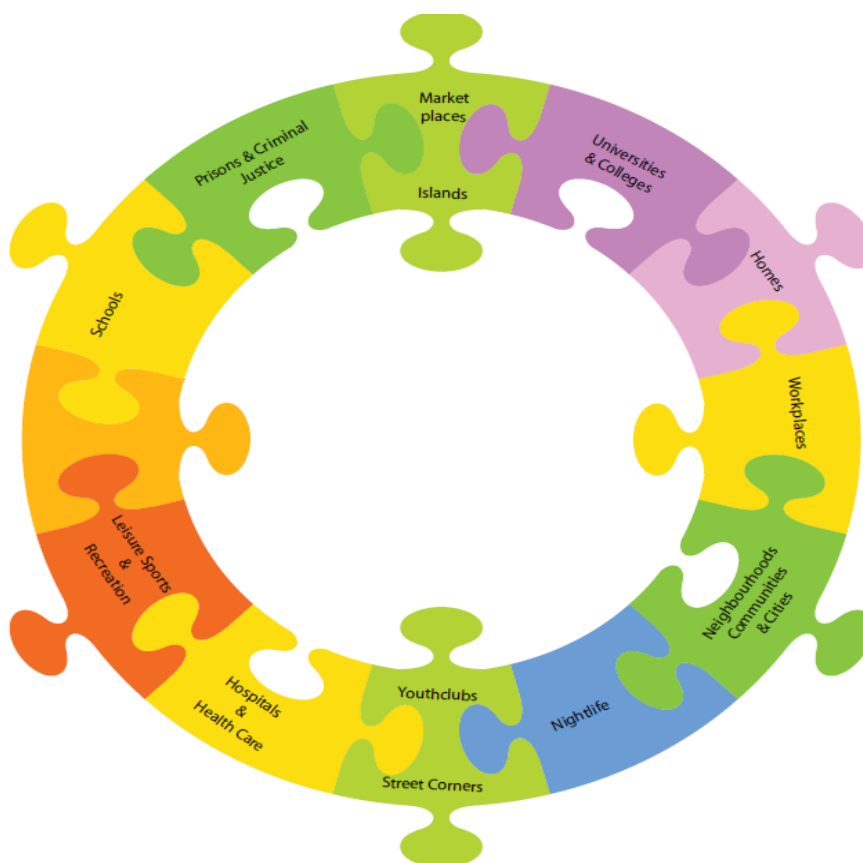


Figure 2: Linking the settings (adapted from Dooris 2004)

The outcomes that result from working within a settings framework for understanding health would include changes in environments, policy, skills and organisational processes in addition to, changes related to specific health problems (Grossman and

Scala 1993). Working for better health using a settings approach does not preclude a focus on specific health issues and can therefore serve two purposes: addressing a specific health problem and developing the problem solving capability of the organisations, involved in that setting (Hawe and Noort et al 1997, Bloch et al 2014). The papers within this thesis can be said to work to serve both of these purposes.

Poland and Krupa et al (2009) suggest that the settings approach to improving health increases the likelihood of success in terms of positive health outcomes, because it offers opportunities to situate practice in its context:

Members of the setting can optimize interventions for specific contextual contingencies, target crucial factors in the organizational context influencing behaviour, and render settings themselves more health promoting (p505).

The underlying principle of settings for health is that investments in health are made within social systems in which health is not necessarily the main remit (Dooris 2004). This would support work carried out within this thesis and presented in the papers included. Hospitals and other health care settings where hierarchical systems exist are distinct from those less formal, open settings such as homes and communities (Dooris 2004, Poland et al 2000, Whitelaw et al 2001).

This thesis presents published papers, which have explored understanding health, across a number of settings where health is, or is not, the organisational remit. Section One of this thesis presents papers, which discuss the role of the nurse in helping people understand health, and promote health within a variety of practice arenas. I have drawn the papers in this thesis together using the settings concept. My rationale for using this, is that twenty-first century nursing practices across a diverse range of settings which include: communities, health agencies, environmental agencies, schools, workplaces, neighborhood centres and with a range of populations such as the frail, elderly, homeless, smokers, teen mothers, the unemployed and those at risk of diseases. Thereby, nurses can be said to work across a variety of settings whose focus is either directly or indirectly, on health. In the context of this thesis, I am therefore taking the position that a setting is one in which, people spend significant parts of their lives, where health may be addressed as a specific problem (Bloch et al

2014) or, as one which Hawe and Noort et al (1997) suggest, develops skills in understanding and problem solving health with people involved in that setting. The next chapter will present a commentary of previously published work, which discusses the role of the nurse in understanding and promoting positive health. This is where my interest in helping people understand health took its roots. The format of this next chapter will be one that comments upon the different papers and how others have cited them.

Chapter 4: Helping Nurses Understand Health to Promote Health in Practice.

Introduction to papers 1-5

There are many interpretations and perspectives of health, the promotion of positive health and helping people to understand their health. The ultimate goal in understanding and improving people's health is to make a difference to the causes of ill health and disease, rather than just focusing on the consequences of it. This, for nurses can be somewhat of a challenge as many face the consequences and constraints of focusing on the causes of ill health and disease in their day-to-day work. Modern nursing should however, involve much more than addressing symptoms. It should concentrate on the causes of ill health rather than responding to its effects; it should actively consider the health needs of individuals and communities and develop initiatives to respond to such needs; it should plan initiatives on the basis of local needs evidence and national health priorities rather than custom and practice (Latter 2001, RCN 2012).

My passion for helping people to understand their health and, subsequently work towards positive health is, inherent in the title of the thesis and maintained throughout. Health has always been conceptualised as being something that means different things to different people. Even to the same people it can mean different things in different contexts. These complexities lie in the different understandings of health and illness whose concepts are also multifaceted and contested (Blaxter 2010). Health at one end of the polarity is viewed from a medical perspective: the causes of ill health are considered to be due to disease and biology. At the other end of the broad definition, poor health is caused by socio and economic factors (Douglas 2007). The holistic practice of nursing involves working with individuals, their families, communities and populations.

Nurses are in an ideal position to influence the people they interact with, empowering them to achieve positive public health outcomes. Whether this is by engaging in primary prevention, taking action to reduce the incidence of

disease; or through secondary prevention, by systematically detecting the early stages of disease and intervening before full symptoms develop; or through good health teaching and the promotion of self-care management, it is nurses who remain a key influencing contact (RCN 2011 p2).

Therefore, addressing disease prevention, promoting positive health and extending life is what nurses do in their day-to-day work.

This chapter will provide a commentary of the following papers, which have been and continue to be, cited both nationally and internationally. I will draw on some examples of such citations to support my discussion. The papers I present in this chapter focus on helping undergraduate nurses to appreciate health as a positive concept, which can be promoted through their nursing practice.

Papers 1-4

- 1. Holt M, Warne T (2007) The educational and practice tensions in preparing pre-registration nurses to become future health promoters: a small scale explorative study. *Nurse Education in Practice*. Vol 7 (6) pp373-380.**

This paper highlights the consistency in UK Government and nursing policy of the role of the nurse in contributing to the health of individuals and communities. The educational curricula of pre and post registration nursing programmes has responded to such health policies by placing greater emphasis on the role of the nurse in health promotion and ill health prevention. This paper explores how pre-registration student nurses in one university experience the impact of these factors on their preparation for practice. We undertook a small-scale explorative study using a convenience sample of second year pre-registration student nurses (n = 100). Data were collected via focus groups, and from student evaluations of practice placement experiences and self-reported learning outcomes relating to health promotion practice. The findings suggest a dichotomy between what is espoused in the underpinning theory of the curriculum and what the student nurses actually experience in practice. The study highlights some of the difficulties that student nurses have in effecting the professional and policy objectives, and argues if nurses are to turn health promotion rhetoric into reality then health promotion practice needs to be more effectively actualised.

2. McCarthy J, Holt M (2007) Complexities of policy-driven pre-registration nursing curricula. *Nursing Standard*. Vol 22 (10) pp35-38.

This discussion article presents an overview of the challenges faced by myself and another nursing colleague, when incorporating current health policy into a new pre-registration nursing curriculum. The article contrasts public health and E learning as contemporary policy areas, which we as nurse educators, were endeavouring to implement within our own pre-registration nursing curriculum. We argue that in order to avoid maintaining the status quo in terms of policies and practice, there is a need to consult with everyone involved in nurse education. This we propose is a crucial part of the curriculum development process. In this paper, we suggest that there is error in trying to ensure that current policy drives the curriculum because, by doing so, the undergraduate nursing curriculum is stretched to a point where the theory-practice gap becomes inevitable. We propose a greater dialogue between policy makers, placement and education providers in order to overcome some of the issues discussed.

3. Jack K and Holt M (2008) Community profiling as part of a health needs assessment. *Nursing Standard*. Vol 22 (18) pp51-56.

The impetus for this article was the white paper *Saving Lives: Our Healthier Nation* (Department of Health (DH) 1999) which underlined the need to tackle health inequalities and promote good health. The document set out targets to reduce morbidity and mortality, with a focus on coronary heart disease (CHD), cancer, accidents and mental illness (DH 1999). The white paper *Choosing Health: Making Healthy Choices Easier* (DH 2004a) also focused on the reduction of inequalities and the part that communities lay in health improvements. Profiling as a way of identifying the community, its characteristics, and needs forms an integral part of health assessment and is essential to reduce health inequalities. This article, written in the form of a learning tool for nurses, outlines the process of community profiling, and considers the different concepts of health, the community and need. The aim of this article is to increase all nurses' knowledge and understanding of community profiling in health needs assessment, and its importance in contemporary nursing practice. The concept of community profiling is discussed and how it can be used to assess health priorities. There is a discussion of the effects of inequalities on a person's health. Different types of need are identified and the benefit of involving

the community in the decision-making process is explained.

4. **Holt M (2008) The educational preparation of student nurses as communicators of health and wellbeing. Perspectives in Public Health. *Journal for the Royal Society in Public Health* Vol 128 (4) pp159-160.**

I was invited to write this discussion paper for an editorial special edition of a journal. The paper focuses on the area of bridging the gap between theory and practice in terms of developing student nurses, as effective communicators of health messages. The paper draws upon the work we were undertaking in developing our own pre-registration nursing curriculum. It discusses how to encourage student nurses to analyse gaps between theory and practice, in terms of communicating health messages to patients and others. The paper argues for modules of study that focus upon the promotion of health and wellbeing, as providing opportunities for student nurses, to consider theoretical frameworks and practise such skills. The paper does acknowledge the multi-factors that may influence the nurses' ability to act as communicators of health and wellbeing. However, the paper argues that the undergraduate pre-registration nursing curriculum is the significant instrument for primary socialisation, in developing and assessing nursing skills for communicating health and wellbeing.

Commentary Papers 1-4

I came to write papers 1-4 as a novice researcher when studying for an MPhil where I was encouraged by my supervisor, to start publishing something to offer nursing practitioners. I was at the time, a senior lecturer in nursing with a teaching focus and curriculum development role in health and the promotion of health. The pre-registration nurse curriculum in our organisation was, at that time, preparing for the required Nursing and Midwifery Council (NMC) professional review of its content and purpose. I was a new member of staff and had joined the teaching team as the changes were beginning. My responsibility was to revise the content of the curriculum that focused on health and the promotion of health. My initial review of the pre-revised module revealed it to have a somewhat eclectic content, representing what Halliday (2002) describes as professional territory. Its content reflected the

professional skills, knowledge and academic interest of the tutors, who delivered the teaching. The module content mainly focused on behaviour and lifestyle changes. This is perhaps one of the most difficult barriers in the perception of health for some nurses to overcome; to perceive health only as the absence of disease or unhealthy behaviour. Pender et al (2006) propose that the nursing profession interprets and defines health as, either subjective to the individual or, that which takes into account the individual interaction with the environment. These definitions and values should shape nurse education and the understanding of health within nursing. Both interpretations also sit well with the healthy settings ideology. The pre-revised module within our curriculum reflected a narrow individualist ideology with no reference to the socio-political health role or, the social context in which people engage in daily activities. The module therefore tended to reflect what (Whitehead 2007) would suggest as an outdated nurse education curriculum, rooted in the medical model. At the same time that our curriculum changes were taking place I was also receiving both informal and formal feedback from students, regarding the issue of a theory-practice gap in relation to health and the promotion of health within nursing. This was valuable information for me, and helped me to begin to understand student experiences and opinions with regard to health, health promotion and wider health issues in nursing.

Dewey (1929) suggested that we 'inquire' into situations, which have a dysfunctional component. It seemed to me that student nurses, whilst understanding health as a positive concept to be promoted, did not relate this to their practice. Paper 1 was my initial inquiry into what I had identified as being, a dysfunctional component between the theoretical input of the undergraduate nurse curriculum within our university, and the practice reality. My aim in this initial inquiry was, to try to ascertain how the students perceived their role in promoting positive health, with patients and clients within their practice. Thematic analysis seeks to find common themes that link from story to story. It is the way in which diverse experiences or ideas are linked together, juxtaposing and connecting the different features of the data (Braun and Clarke 2006). I used thematic analysis to search for central themes that emerged from the data. Two central themes (theory-practice realities and curriculum development) which were derived from the data provided the impetus for this, and the subsequent publications in this first section of the thesis.

Nursing and Health

The concept that nurses are in a prime position to help people understand and improve the health of individuals is consistent in past and present policy. Firstly, it is important to consider why nursing and its practice is targeted in helping people understand their health and the promotion of health. One of the key factors is the unequivocal numbers involved. The WHO (2009) World Health Statistic Report suggests there are 17.6 million practicing nurses worldwide. It is important to note however, that this is just an informed estimate of the WHO and figures are likely to be greater, if we consider the potential for unregistered nurses in countries that have inaccurate systems for recording professional registration. In 1998, the Royal College of Nursing (RCN) proposed that the nursing workforce was a 'sleeping giant' in terms of its potential and impact, which nurses could make on the promotion of health (RCN 1998 p12). Pender et al (2006 p10) optimistically consider if such an occurrence was to eventuate:

Nurses, because of their biopsychosocial expertise and frequent, continuing contact with clients, have the unique opportunity of providing global leadership to health professionals in the promotion of better health for the world community. Nurses should serve as role models of health-promoting lifestyles and as leaders to activate communities for health promotion. Nurses, as the single largest group of health care providers, should play a vital role in making health promotion and illness-prevention services available to all population groups, including those who are underserved and vulnerable.

It is not difficult to imagine the phenomenal impact that 17.6+ million nurses could have on helping people towards positive health if this 'quiescent' profession were actuated. The reality is however, as indicated within all the papers in this section and others who cite these papers, that those expectations have not yet materialised (International Council of Nurses, 2011, Whitehead and Irvine 2011).

Health policy should significantly contribute to the development of pre-and post-registration nurse curricula, placing greater emphasis on the promotion of health and ill health prevention, as an activity involving all nurses. Previous studies by Benson and Latter (1998), Macleod Clarke, and Maben (1998) for example, examined similar issues that my own research did in paper 1. They suggested that the preparation of nurses for promoting health, required serious attention in order to meet the challenges

of the 21st Century. My own work in paper 1 would suggest that despite such policy and curriculum development, to date little has changed. Whitehead (2009), in his work on barriers to the promotion of health within nursing, refers to paper 1 in this thesis acknowledging such and that that the literature is rarely:

Complimentary of the nursing contribution to past and current health promotion (p865).

He does however; offer me some reassurance and a reminder that, despite others and my own works reporting this as a recurring and common theme:

It is never too late to progress and it is in the best interest for nursing to proceed with widespread reform (Whitehead 2009 p864).

A Meaningful Curriculum to Support Practice

Nursing is carried out in a constantly changing world and is driven by policy demands to meet the needs of people at every critical point in their lives. These policies act as drivers to assist educational organisations in their development and provision of programmes of study; meeting both customer needs and the business portfolio of the educational organisation. One of the roles of nurse educationalists is to strive to meet the demands of NHS reforms through a meaningful nurse curriculum. This is the challenge of turning theoretical policy rhetoric into practice and reflects the content of papers 2 and 5 in this thesis.

In 1993, MacLeod Clarke suggested that the shift from sick nursing to health nursing is philosophical and not simply an act of adopting or changing nursing activities. Such arguments are still being reflected in current nursing policy and literature (e.g. Henderson 2006, Greengross and Sturdy 2013). Nurses learn and adopt such values through nurse education, which has a significant influence on culture change in nursing. It has the capability for preparing nurses to appreciate the political context of health and the skills to effect change in practice. Socialisation into nursing starts in foundation nurse education. Here, students learn about and begin to understand the profession (Karaoz 2004). The enhancement and development of nursing as a profession, depends upon nurses who enter qualified practice, with firm

epistemological, ontological perspectives and a clear conceptualisation of its values. Nurse educationalists constantly strive to meet the demands of NHS reforms, through the development and re-development of the nurse curriculum. The consequence of this was the focus of paper 2 where, a colleague and I considered this from two perspectives. The difficulty with meeting such curricula demands for nursing practice, is that certain concepts may become less transparent or lost. In the context of this thesis, we found that, in our endeavour to meet an ever-changing health service, certain aspects such as the importance of understanding health as opposed to illness as part of the caring role, had become somehow lost within our own curriculum. Spouse (2000) argues that as student nurses enter the profession they have preconceived ideas about the practice of nursing. She adds that, strengthening or altering such perceptions, is dependent upon how the students are supported throughout their education and training. Whitehead (2009) suggests that nurses continue to view health and the promotion of health in the physical and biological context within a biomedical framework. The context of health is thereby, considered one that is a negative state and absence of disease. Papers 1, 3 and 4 advocate for nurse education to view health in its broadest sense. Both Wand (2011) and Whitehead (2009) cite our argument in their work adding, that we must consider the promotion of health in its true context. They suggest that this requires an understanding of how individual health is influenced by social, cultural, political and economic conditions in which people live. This conflation of concepts is something that is highlighted in all papers within the first section of this thesis and is cited and supported by Wand (2011), who proposes that, many nurses conceptualise understanding and promoting health, as being that of changing behaviours. Walthew and Scott (2012) in their citation of paper 1 propose that nurses do in fact, understand the wider influences on health but lack the knowledge and skills, to become involved at a political level. However, they again make reference our own argument that often despite this, nursing practice is one, which is still limited to information giving (Walthew and Scott 2012). In his citation of our work in paper 1, Piper (2008) proposes that this lack of a clear conceptual and epistemological position that we suggest, is why nursing has yet to make any major impact on the promotion of health.

The need to provide a meaningful nurse curriculum content to develop skills in understanding people's health was the driver for paper 3. In the paper a colleague and I argue that some nurses, in particular newly qualified nurses, are ill equipped to understand, assess and meet the needs of communities across both acute and community settings. Sakellari (2012) draws upon our paper to support her argument for health needs assessment skills, to be developed in health visiting curricula in Greece. She urges that in relation to the education and preparation of such roles:

Future studies need to consider the criticism of previous published studies and apply them in their research questions (Sakellari 2012 p24).

Whilst it is reassuring to note her support, we would argue further that the ability to understand and apply the skills for health needs assessment, needs to be addressed across all nursing settings. In addition to this, we suggest that helping people towards positive health should for nurses, be a collaborative endeavour. Johnstone (2009), in her citation of paper 3, further suggests that the nurse curriculum should extend itself to inter-professional learning for student nurses. She proposes that there is a need for student nurses to acquire the knowledge and skills that effectively meet the sexual health needs of young people they work with. Tinnon (2010) in her PhD thesis refers to paper 3 in her work on socioeconomic characteristics, environmental risk, and the impact of the built environment on health in Mobile County, Alabama. She discusses the importance of health and the assessment of health needs, from a focal point in the future of environmental justice. Whilst she acknowledges the usefulness of health needs assessment, she proposes that such a framework can be inadequate and that it is much more revealing to use a health inequity index. She advocates this as a new conceptual framework for researchers and citizen activists, in their pursuit of environmental justice.

The undergraduate nurse curriculum should be a significant framework for developing knowledge and skills to help people understand health in different contexts. Latter's (2001) study concluded that pre-registration nursing programmes were varied in their wider health content. Most focused on behaviour change and lifestyle practices which attracts much criticism for its narrow perception of the nurses role in helping people understand health (Seedhouse (2004) and Whitehead (2004, 2005, 2009). It also

reiterates the very narrow concept of nurses' contribution to understanding health that the papers in this thesis argue as one, which is purely disease focused. There is much debate around the image of nursing. In TV drama, it is depicted as being exciting and very clinical; an image that student nurses present at their interview. Lenzer's (2003) offer such criticism of TV nursing and medical dramas quoting Diana Mason, editor in chief of the *American Journal of Nursing*, who suggests that 'every nurse considers going to medical school'. She points out:

If you ask most nurses if they had a choice... they would choose to be nurses, so why are they portraying every nurse as a doctor wannabe? (Lenzer 2003)

Paper 1 in this section of the thesis highlights that our student nurses revealed a consistent and marked reluctance to embrace anything other than a clinical role. Their criticism of the curriculum was the need for more time to study what they considered were 'more useful and exciting topics' such as clinical skills. This again reiterates the very narrow concept of health as one, which is purely disease focused. Latter and Westwood (2001) argue that the level of students' understanding of such concepts is symptomatic of their tutors' knowledge, and capability to convey such information. Assisting student nurses in developing skills to put into practice is a fundamental part of their education. As nurse tutors, we can be guilty of reinforcing positive or negative interpretations of health and subsequently, how we help others to understand their health and this can be done in a number of ways. Barrett (2007) suggests that a strong knowledge of the subject areas is a prerequisite of effective teaching, in all aspects of nurse education. However, putting our teaching into silos and preferring to teach only the subjects that have a particular interest to us can, as Halliday (2002) has described, create 'professional territory'. This was highlighted to me in research that was reported in my MPhil thesis (Holt 2013) from participant comments such as:

I never really became involved in promoting health as you can't really in intensive care or theatre, can you'? (Nurse Tutor)

Another example is focusing on the business agenda of the Higher Education Institution (HEI) and their recruitment strategies and needs:

We need to make it (nursing) appealing to potential new students. Get them in the labs and show them something exciting (A Manager)

This led me to suggest that we might be unaware that our expressions, priorities and interests may have a lasting impact on students. Reinforcing positive or negative interpretations of health to nursing students can also be done more formally, through what Whitehead (2007) suggests is a curriculum, which focuses on pathological and physiological abnormalities as common modes of delivery, which seek to teach measures to cure. All of these examples can have an effect on nurses' perception of what health may be and how they then interpret that into their practice.

The inclusion of helping people understand and work towards positive health within the nursing curriculum was addressed across Europe by the WHO (2000); calling for an inclusion of health and the promotion of health in all nursing curricula. Despite this, more recent nursing policy is still calling for nurses to embrace this role (Bennett 2014, DoH 2010, DoH 2011, RCN 2012). The papers in this section of the thesis, those who have cited these papers and others, have reported that whilst this may be happening, there is little transference of that theory to practice:

Students are either exposed to the theoretical and educational foundations of health promotion but do not then witness them or they are not encouraged in practice—or they are not exposed to the theoretical foundations at all (Whitehead and Irvine 2011 p249).

Valaitis (2008) in their citation of paper 1 add further that this lack of opportunities also devalues the role of promoting health for students in clinical placement.

Theory Versus Practice Reality

Papers 1 and 2 highlight the difficulties that students have in putting theory into practice. Opportunities for nurses involving one-to-one encounters with patients in helping them understand their health, are often limited, missed or resisted. I found this view was not confined to a single cohort of students within our organisation and for me, was very de-motivating. Some students were frustrated in their attempts at engaging with patients regarding health issues because these attempts were often contradicted by trained staff, making them reluctant to try again. This lack of opportunity and time to engage with patients about their health was often attributed to

a task-centered approach to nursing practice. Wand (2011) acknowledges this argument outlined in paper 1 to support their work in mental health promotion.

The ability to develop their skills in promoting health was influenced by the type of setting, where students experienced their practice. This was usually in a community setting, where our students reported having more time to talk to patients and subsequently more opportunities to discuss the factors, which may influence their health. Our findings were cited by both Wand (2011) and Whitehead (2009), who suggest that nurses working in traditional acute based institutional services, are likely to face more challenges in promoting health than those working in community settings. Hospital wards are not very private places where health issues with patients can be discussed. This, and the fact that some nurses are not able to view patients in the context of their social setting, prevents nurses from identifying opportunities to engage with patients about their health. Healey and McSharry (2010) in their citation of paper 1, support our argument by suggesting that the absence of a suitable role model in clinical practice makes it difficult for students to engage effectively, with the promotion of health with their patients. Little (2013) in their work on graduating nurses, acknowledge our concerns regarding the ability for nurses to be able to transfer their acquired knowledge and skills, to the acute setting. They add further that:

Placements with School Nurses and Health Visitors appeared to give emotional health assessment much more credibility than in the acute setting. The community setting appeared to assist some interviewees to consider the impact of the home and school environment on the child's emotional health within their subsequent placements. Some did appear to be able to transfer the acquired knowledge and assessment skills to the acute area (Little 2013 p8).

Carr (2001) and Fretwell (1980) both offer a perspective on this which suggests, that within the hospital setting the practice agenda is somewhat predetermined with respect to the patient's illness or problem. They explain that placing the consultant's name above the patient's bed, focuses patient and professional attention on the illness or problem, thus providing a paradigm of care. Hill (1998) in her work with student nurses and health promotion proposes that whilst students were learning the practice of placing patients at the centre of their practice for the promotion of health, the

system and those who worked within it, still made it difficult. Little has changed; as such, hegemonic power appears to be still evident today in both my own published work, and those who have cited them. For example, Dahl et al (2014) discuss such hegemony in terms of the contradictory discourse between, the promotion of health and disease prevention within the Norwegian public health nursing curricula. Barnett et al (2102) ask how can universities best prepare student nurses to contribute to healthcare reform, whilst dealing with the hegemonic powers across different professional and organisational cultures (e.g. medicine). Aguiar et al (2012) discuss the need for mental health nurses to develop the necessary competencies for the practice of health promotion and confront the current challenges, in mental health reform. They suggest that this is fragmented and hindered by the hegemony of psychiatric knowledge about care. Boozary and Dugani (2011) in their citation of our paper 5, allude to our idea of hegemony as they struggle with a medical model curriculum content for student doctors. Clinical placements are a time when contextual learning takes place as nurses become engaged in the experiences of the patients. It would still seem, that the idea about hospitals not being conducive to nurses effecting a health promoting role, continue to be reflected despite innovation in concepts such as health promoting hospitals, which have emerged in the past two decades.

These initial four publications were written as a result of a search for answers and a quest for a voice in the clinical world that dictates changes in nursing practice. How could I help nurses, in particular student nurses, understand the impact they could have on promoting health? I was making some strides within my own organisation in terms of curriculum development and at the same time was successful, in winning a small externally funded project entitled *Brief Intervention training for undergraduate nurses in Cheshire and Merseyside: A three-year evaluation study* (CHAMPS 2012). We presented the findings from the study at Nurse Education Today conference 2012 in Sydney Australia. My work was slowly being recognised across the nursing sector and at other conferences. Subsequently I was approached to write the two following book chapters.

Book Chapters:

Holt M (2011) Health promotion and communication techniques. *Nursing: Communication Skills in Practice*. Oxford University Press

Holt M, Webb L (2011) Engagement, motivation, and changing behaviour *Nursing: Communication Skills in Practice*. Oxford University Press

The invitation to write these book chapters was something of a breakthrough and turning point for me. They brought the work I had done thus far, specifically to the attention of the field of nurse education and a wider audience of those contributing to skills development in nursing. I was invited to write these book chapters to support student nurses as effective communicators of health. Both chapters are an accumulation of my work over the past few years in developing the undergraduate nurse curriculum within my own organisation. One of the key features of these book chapters was the mapping of the content against the Nursing and Midwifery Council (NMC 2010) standards for nurse education and practice. This meant that my work was at the cutting edge of both education and practice within nursing. This, and policy changes within health, led me to write paper 5 within this thesis.

Paper 5

Holt M (2011) Public health and nursing practice: Seizing the receptive moment. *Nurse Education In Practice*. Vol 11 (4) pp224-227

This discussion paper highlights the continuing debates and criticisms around the role of the nurse in the public health arena. It draws upon work undertaken as part of nursing curriculum development within our own organisation, and the learning that has taken place from this. It presents a discussion of some of the issues raised from student nurses, nurse lecturers and nurse managers that worked with us in our revalidation of the pre-registration curriculum. The aim of the paper is to consider what is needed to put public health at the core of all and every nurse's practice, across the UK. It takes the approach of lessons learned as it discusses some of the changes made to our own organisations undergraduate nurse curriculum, and those changes which still need to happen, in order for nursing to identify its public health capacity. It suggests that these changes are easily transferable across all UK nursing curricula. It takes the stance that, never before has public health been so much at the forefront of national agendas as we go towards a new public health agenda. It argues that this is an opportunity for nursing as a profession, to rise to the public health challenge and

seize the day. It proposes that as we go towards a new public health agenda, the timing is right. It is the receptive moment for all nurses to identify their public health capacity, and all take their place in the practice of public health in its very broadest sense

Commentary Paper 5

This final paper in this section was in effect an attempt to draw all my work together thus far and re-nudge nursing into considering its role in health and the promotion of health to, seize the moment. At the time the UK was reshaping public health and health in England and I had, over the past few years, read various public health policies and listened to numerous speakers, who consistently began their presentations by explaining that never before has health been so much at the forefront of national agendas. It really did seem that health and all its underpinning components were taking centre stage, gathering momentum in the challenge to improve the population's health. At the same time (2011), I attended a UK public health conference to hear Sir Kenneth Calman speak of current policy drivers in health. During his speech, he was asked why banning smoking in public places had eventually become legislation. His brief response was that the timing was right; it was in effect then, the receptive moment. This gave me the impetus for writing the final paper in this section. The ideology behind receptive moments underpins behaviour and change management theory, emphasizing the importance of cues in effecting motivation for change. Interestingly, the term 'receptive moment' became the new coalition government rhetoric for a new public health service (HM Government 2010).

Changes were also occurring again across nursing practice to meet the demands of this new health services, and this meant changes to nurse education. I attended a nursing conference run by the RCN in late 2011, which focused on the need to promote health and develop the competencies to do this, within the role of the nurse. I became excited that maybe we were at last seizing the receptive moment. What was disappointing for me was that the speakers only related this development, to post registration nursing programmes and not undergraduate pre-registration programmes. I raised this as an issue for debate at the conference that surely we should begin to instill such knowledge, skills and values in both current and future nurses. In September 2012, I was invited to become a member of a working party for central

Government led by the Director of Nursing at the Department of Health, and Principal Adviser on public health in nursing. The focus of this was to develop a new framework of competencies to promote health in all nursing disciplines and settings (RCN 2012). The contribution that my research makes in such a forum enables me to be at the cutting edge of changes in the role of nursing and health in England. It can contribute to both nurse education and the disciplines of health in general, as we consider how to change the culture and working practices, of a profession in framing health and the promotion of health within nursing. Once again, I found myself at the heart of curriculum revisions in order to meet the new requirements for nursing practice. The changes that I had naively assumed would occur, simply because I was a practitioner respected within the research community, had taken over four years to implement within our own organisation. It was becoming increasingly easy for me to appreciate criticisms of nursing with regard to its slow pace in embracing a health-promoting role (Piper 2009, Whitehead 2009).

With complex concepts such as health and the promotion of health, professions such as nursing develop models or frameworks, to suggest ways of working with them. In line with new UK policy changes in health and the need for nursing to develop itself in this arena, The Royal College of Nursing (RCN 2012) responded with a conceptual framework for practice, based upon three overlapping principles (see Figure 3). Underpinned by the assessment of health needs, which we argued for in paper 3, the framework identifies some of the key areas within which all nurses can promote health, protect from harm and prevent ill health and disease. The framework seemed to me, to address the possibilities for all nurses to engage in health related issues. For example, the incidence of disease can be reduced by adopting preventative measures, and nurses can contribute to health protection by developing policy and practice relevant to their roles and settings. Boozary and Dugani (2011) in their citation of paper 5, look to developing a *think tank* in order to address the inadequacy of curriculum content, regarding understanding health in their Canadian medical programmes. This is an interesting reference as they relate the difficulties they have in Canada, in producing medical students who they believe:

Feel excluded from the process of shaping health policies, or at worst, disengaged and ill prepared to tackle the challenges they will confront in their

professional lives (Boozary and Dugani 2011 p260).

Their argument basically being, if other professional programmes such as nursing have not yet embraced this, then how far down the line are students of medicine? All nurses need to think beyond the immediate problem and to the social and environmental factors that can improve health (Whitehead 2004, Seedhouse 2003). The RCN (2012) framework enables nurses to consider patient lifestyle choices within the wider range of determining factors, which influence health and wellbeing.

Summary

The many authors who have supported the commentary in this section of the thesis are in one sense on the same page as I in terms of nursing and the promotion of health. However, I do appreciate that our individual perception about what this may mean for nursing practice may be different. For example, Whitehead (2004) proposes advocacy as the very basics of nursing's contribution to health, not that of tasks such as observations or medicine rounds. My own perception differs somewhat and suggests, that these do in fact offer the very basics of nursing care to promote positive health. A medicine round as one example is an ideal opportunity to offer advice, knowledge and examine patients' cultural beliefs, their family involvement, and anything that relates to empowerment towards positive health. Whitehead (2004) and Piper (2009) urge nursing to be more radical in the field of health promotion and public health in order to change practice. However, the ability to actualize this is often fraught by complex issues and requires leadership, vision, and strong organisational support.

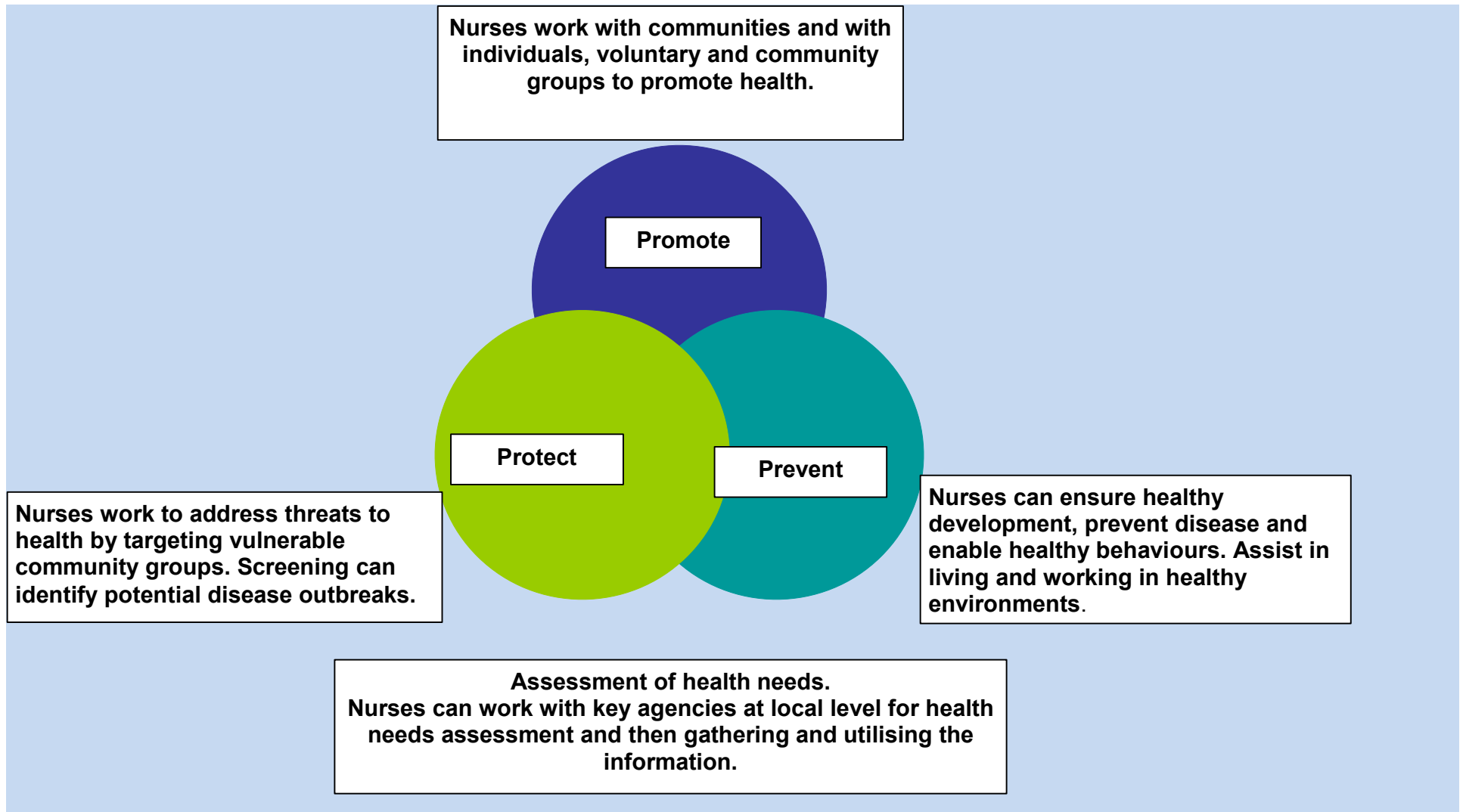
Education has a significant influence on culture change in nursing and has the potential for both self-development and practice development. The papers in this chapter have predominantly called for pre-registration nurse education programmes that effectively prepare all nurses as agents of health. The undergraduate nurse curriculum has, the capability for preparing nurses to appreciate the political context of public health, and the skills to effect change in practice. The underlying theme across the papers in this section is the need to initiate a slight change and revisit nursing and its values. The undergraduate curriculum is the key to addressing changes

in nursing. This is how the epistemology of nursing makes its connection to its own axiology. These educational programmes ensure:

That the students acknowledge and understand the profession (Karaoz 2004 p129).

Therefore, improving and developing the profession depends upon students who enter the world of qualified practice, with sound epistemological (knowledge), ontological (being) perspectives and clear conceptualisation of its values (axiology). Nightingale reminds us of the importance of teaching those students who would have the responsibility for the health of others. There is no national curriculum for nurse education, with Higher Education Institutions having autonomy on the structure and content of the curriculum. Therefore, in an effort to enable nurses to engage with the ethos of a constantly changing healthcare setting, nurse educationalists are consistently developing and re-developing the curriculum. Our nursing students are the practitioners and leaders of tomorrow and through these students their knowledge, skills and values of health will extend beyond our own university, as they effect change in a variety of practice settings. An exploration of my journey so far illustrates a quest to help nurses understand health and the promotion of health, by placing positive health at the core of the nurse curriculum. I began my journey into research thinking I was going to dramatically and quickly, change the world of nursing practice. This was a somewhat naive assumption on my part, as I realised that it was probably not going to be on such a grand scale as I had originally thought, and would certainly take time. What was achieved in this period was, a greater wisdom about the limitations of the academic practitioner voice, and the practice gap that goes much deeper than simply, a problem of practitioners acquiring knowledge and skills. Change in nursing practice tends to be incremental in nature and although current nursing policy may suggest that the professions might have seized the receptive moment; it needs to maintain the momentum and rise to the challenges of being agents of health in their everyday practice. The following pages 49-120 inclusive are papers 1-5 discussed above.

Figure 3: A Framework for Health in all Nursing (adapted from RCN 2012 p14)



Paper 1: Holt M, Warne T (2007) The educational and practice tensions in preparing pre-registration nurses to become future health promoters: a small scale explorative study. *Nurse Education in Practice*. Vol 7 (6) pp 373-380.

Paper 2: McCarthy J, Holt M (2007) Complexities of policy-driven pre-registration nursing curricula. *Nursing Standard*. Vol 22 (10) pp35-38.

Paper 3: Jack K and Holt M (2008) Community profiling as part of a health needs assessment. *Nursing Standard*. Vol 22 (18) pp51-56

Paper 4: Holt M (2008) The educational preparation of student nurses as communicators of health and wellbeing. *Perspectives in Public Health. Journal for the Royal Society in Public Health* Vol 128 (4) pp159-160.

Book Chapter

Holt M (2011) Health promotion and communication techniques. *Nursing: Communication Skills in Practice*. Oxford University Press

Book Chapter: Holt M, Webb L (2011) Engagement, motivation, and changing behaviour. *Nursing: Communication Skills in Practice*. Oxford University Press

Paper 5: Holt M (2011) Public health and nursing practice:
Seizing the receptive moment. *Nurse Education In Practice*. Vol
11 (4) pp224-227.

Chapter 5: Understanding Health in Universities

Introduction

The previous chapter presented papers published whilst I was a Senior Lecturer in Nursing. As my research into this area developed so did my role within the university, as I became a Principal Lecturer in Public Health. The predominant feature of this new post was that I became responsible for securing commissioned work in public health for the university. This meant that I moved into new settings for research and projects, which considered health, both in and outside of the university. This chapter will provide a commentary of published papers (6 and 7) from two of these projects. The papers I present in this section focus on understanding health in universities. The format of this chapter will be slightly different from the previous chapter, as these more recent published papers do not yet have citations. The papers will be presented around a commentary on the topic area and supporting literature.

Paper 6

Holt M (2012) The debt crisis: Tackling gambling related harm to students in higher education. *Health and Social Care Education*. Vol 1(1) pp14-16.

This paper was written as part of a larger funded project on the issue of student gambling and its related problems (Powell et al 2012). On reflection, this paper illustrates the difficulty of disseminating parts of a larger piece of research in journal-article-sized portions. This is a constant challenge for academics who are under pressure to disseminate and publish at a constant rate. However this paper translated into a journal article did, serve its purpose in summarising one of the key points of the larger report. It also acted as a pointer to interested readers who may wish to seek out the full report. The paper was presented and wider disseminated at a UK Healthy Universities Network Meeting.

The project had two main aims, which were to increase understanding and raise levels of awareness of gambling-related harm, as an issue within the higher education community in England. Secondly, to develop resources to support students and staff

in order to minimise and prevent gambling related harm. The latter was my own contribution to the project and is the focus of this paper. For the part of the study relating to this paper, focus groups with students and with support staff from Students Unions, Counselling and Student Advice centres (n=8) were carried out. The purpose of the focus groups was to explore the types of resources that staff need to support students with issues related to gambling. From these groups we mapped the awareness of existing resources that focused on gambling-related harm, and other associated services (mental health, addictions) available to students in two universities. This project used an Action Research approach (see Figure 4); a form of self-reflective enquiry undertaken by people in social situations in order to evaluate and improve, understanding of practice and the situations in which the practices are carried out (Carr and Kemmis 1986, Lewin 1951). There are four steps in the Action Research cyclical process, and these are repeated in sequence as work progresses, creating an upward spiral of improving practice.

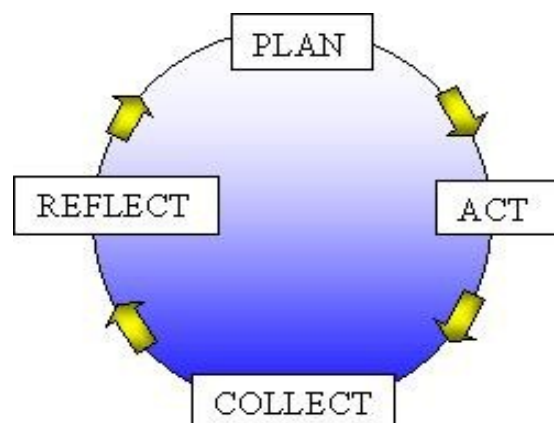


Figure 4: Action Research Cycle (Lewin 1951).

In the context of paper 6, the findings showed: a lack of awareness of types of support services available inside and outside universities for gambling and other addictive-related behaviours. It revealed that accessing support for a gambling addiction needs to be available in anonymous formats (e.g. online) and promoted covertly (e.g.

stickers inside toilets). These findings informed my part of the project, which was the development of a set of resources to support students and staff.

Paper 7

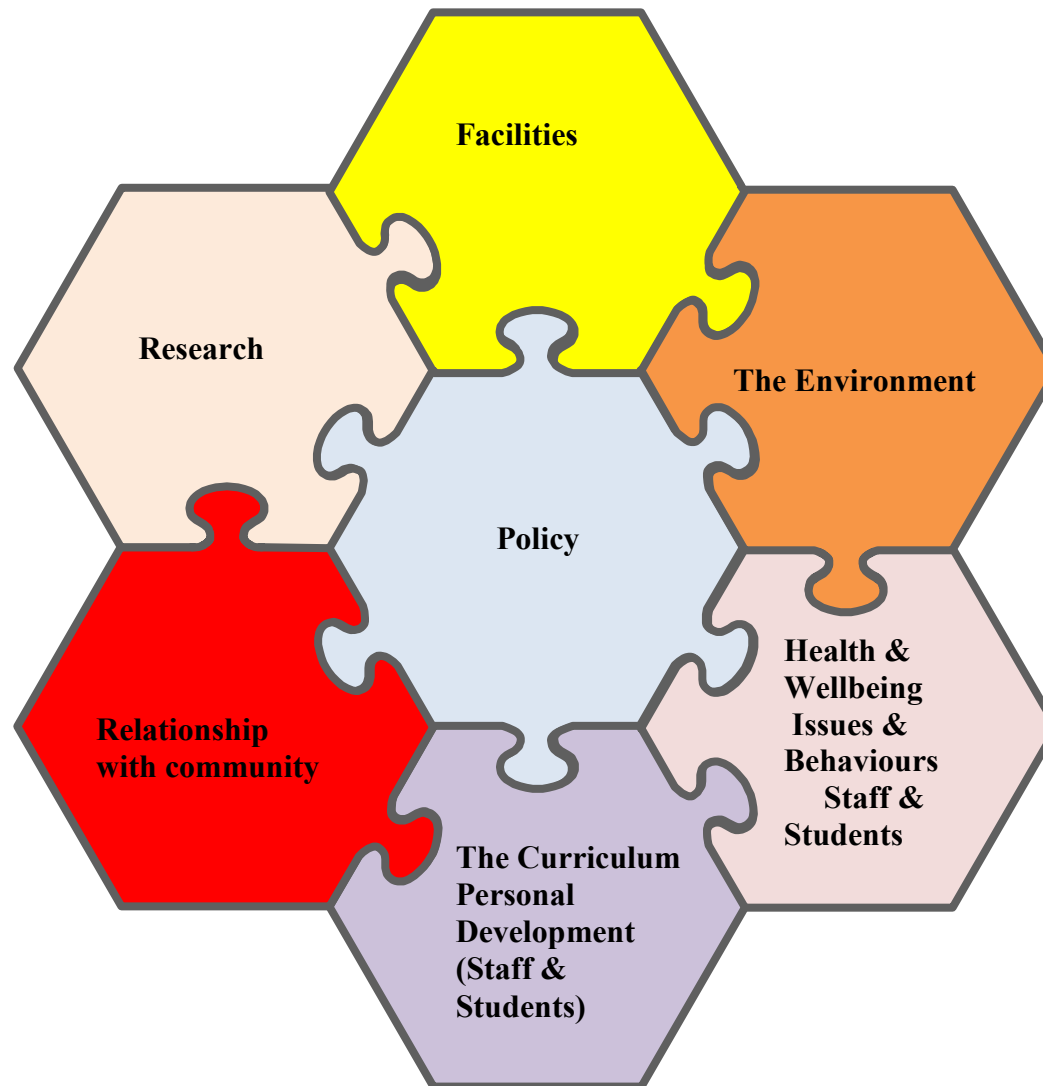
Holt M, Monk R, Powell S, Dooris M (2015) Student Perceptions of a Healthy University. *Health Education In Press* <http://dx.doi.org/10.1016/j.puhe.2015.03.020>

One of the responsibilities of my role in Public Health is that of Healthy Universities Coordinator, which involves driving the development of becoming a 'healthy university' within my organisation. This paper was written as a result of a small amount of internal funding which enabled a wider study, into what some university students across a selection of universities in the UK, believe represents a healthy university. The need to consult with students came as a result of some self-review work we had done within our university as to how we were achieving the concept of a healthy university. Student surveys and focus groups were used to collect data across eleven universities from universities in England, Scotland and Wales. A 'priori' themes were used to develop our own model for a healthy university and for the thematic coding phase of analysis (see Fig 5). A 'priori' themes arise from previously agreed definitions, literature and constructs (Maxwell 2005, Strauss 1987). Ours derived from the frameworks for a healthy university, identified in the Healthy Universities Network England, funded project (Healthy Universities Network, England 2010). The benefit of 'a priori' themes is that they can help the coding phase of analysis, enabling the redefining or removing of themes.

An expression of interest to participate was circulated via the Healthy Universities Network England, to Healthy University Coordinators, Student Union and appropriate support staff to universities in England, Scotland and Wales. Eleven universities participated in the study (7 in England, 2 in Scotland and 2 in Wales). Data were gathered from 423 students studying on a variety of programmes through on site opportunistic student surveys (n= 367) and 6 student focus groups (n=56). The MMU research university's ethics committee gave ethical approval for the research. Opportunistic student surveys asked students to complete in writing, the sentence '*a healthy university is one which*'. Focus groups, students were asked to bring along a

visual object that represented a healthy university to them. This acted as an icebreaker to the session as they were asked to explain the object. This form of pairing of narrative and visual tools is becoming a recognised method for assisting the researcher, in documenting and symbolizing the self-representations of participants (Pink 2001); every picture tells a story. Semi-structured questions were used as focus group prompts and responses were transcribed. Using our 'a priori' themes, the responses from surveys and focus groups were coded thematically. Further sub themes were re-defined from the 'a priori' themes using a form of thematic networks, or web-like illustrations (networks) that summarize the main themes (Attride-Stirling 2001). The findings from the study identify that students in general across all universities perceive a healthy university to be one that provides healthy and reasonably priced food options on campus with free water stations. Access to health services, which meet the needs of the students, is a key feature and an environment, which is conducive to health and wellbeing. The environment in a healthy university would be safe, clean and consider green issues. Student health and wellbeing would be supported by a curriculum, which had student health and wellbeing as an integrated feature of its content. This would be over and above the generic student support services available in all universities and tutors would need to facilitate health and wellbeing through the curriculum. A healthy university would have its own ethos of a 'healthy place' and internal community and would have relevant policies to ensure all these issues were in place.

Figure 5: The MMU Healthy University Model



Commentary

The following commentary will discuss the supporting literature around both papers 6 and 7 within this section that focus on health within universities. Paper 6 identified that gambling is a hidden addiction and one, which is hard to detect and has significant health impact on both gamblers and their families (Ladouceur 2004). Unlike other addictions such as alcohol or drug use, there are no visible external clues to gambling problems. Addiction to gambling is often identified as a result of financial hardship or social consequences. It is estimated that approximately two-thirds of people participate regularly in gambling activities (Sproston et al 2007). The issue of gambling in adolescence and the potential problems associated with it, is a growing public health concern (Messerlian et al 2005). Studies reveal that similar to adults, problem gambling in adolescence may result in health and wellbeing issues such as poor relationships, depression, suicide and criminal behaviour (Derevensky et al 2004). Despite these risks to health and wellbeing for the individual and others, the issue of gambling as a problem for young people, has only just emerged as a significant health concern (Derevensky et al 2000, Jacobs 2000). Both these studies indicate alarming evidence that:

Between 4 and 8% of adolescents have a very serious gambling problem, while another 10–15% are at-risk (Derevensky et al 2000, Jacobs 2000).

A more recent study has suggested an increase in young people becoming exposed to widespread opportunities to participate in both regulated and unregulated forms of gambling (Messerlian et al 2005). Going to university often offers the young person their first move away from home and family and as such, restrictions on their activities tend to be somewhat diminished. There is increasing evidence to show that students in higher education settings are amongst those young people who, are at potential risk of gambling-related problems (Shaffer et al 2005).

Despite the support for problems associated with addictions such as drugs and alcohol for students within university settings; there is little support available that addresses gambling-related harm, in particular within the UK, and it is the context that the study in paper 6 took place. Shaffer et al (2000) suggest that gambling is now one of the

most prevalent of student behaviours – but the one, which is attracting the least amount of attention. Within the UK, many higher education students are resorting to gambling as a means of paying off their student debts (Griffiths and Barnes 2008). At the opposite end of the pole, large numbers of university students are experiencing financial difficulties that are a direct result of gambling (Wood et al 2007). Tutors and other staff in higher education are in a unique position to provide help and support to students who are at risk of developing, or already have, a gambling problem. The difficulty is that there has been relatively little attention paid to determining the resources that tutors and other staff require, in order to screen and identify gambling-related harm, and be equipped to engage effectively in prevention and support.

Healthy Universities

Ecological models of health are inclusive health promotion frameworks that are multi-layered, and focus on the influence of environments on behaviour and other structural factors such as policy, which support individuals to make health choices in their daily lives. The common strand that links ecological models of health is an emphasis on subtle assets within human systems, (for example organisations and communities), which subtly improve health and health outcomes (Krieger 2001). Thereby, pointing to the need to create environmental conditions that support and promote effective and sustainable behaviour change (Townsend and Foster 2011). With more than 2.3 million students and 370,000 staff, (Universities UK, 2008; HESA, 2009), the United Kingdom universities reflect the ecological model of health as environments, for understanding and addressing health issues. Dooris and Doherty (2010) suggest the university as an example of the settings approach, which adopts a whole system perspective, aiming to make places within which people, learn, live, work and play supportive to health and wellbeing. The concept of a Healthy University builds upon the success of other settings such as Healthy Schools and Healthy Cities. The Healthy University approach has the potential to consider both higher education and public health drivers such as inequalities, alcohol, mental well-being, obesity, sexual health, climate change, food and physical activity (Dooris and Doherty 2010). Messerlian et al (2005) propose a policy framework that includes health promotion action areas to support young people with gambling problems. These are to: create supporting environments that develop personal skills, build upon healthy public policy, include

health promotion action areas, reorient health services and strengthen community capacity (Messerlian et al 2005). Such criteria underpin the Healthy Universities ideology. Therefore, in the context of this thesis, understanding the health and wellbeing outcomes of problem gambling amongst students in higher education, sits well within a Healthy University settings concept.

During 2009-2012, Manchester Metropolitan University co-led a HEFCE-funded project entitled *Developing Leadership and Governance for Healthy Universities* (Healthy Universities Network, England 2010). This project collaborated with the Healthy Universities Network, England, the Royal Society for Public health, the Leadership Foundation for Higher Education and a number of universities in England. Their purpose was to develop case studies and guidance tools for those universities aspiring to be a healthy university. A self-assessment tool was developed which when completed, described what actions a university needed to take to become a healthy university. In 2013 I carried out this self-assessment with senior managers across Manchester Metropolitan University and from this exercise, we identified a need to consult further with students, as to what a university that facilitates student health; a healthy university, is for them. A small amount of internal funding enabled the study to consult with a wider student audience from universities in England, Scotland and Wales. The aim of this exploratory study in paper 7 was to investigate what some students, across several different universities in the UK, perceive health to be for them in a university. It should be acknowledged that data drawn from this qualitative study might not be generalized to the overall UK student population.

The students who took part in the study were clearly 'health' conscious and able to articulate the importance of being healthy for them. Health for the students in paper 7 focused mainly on a healthy university environment and its supporting policies that would facilitate the overall student health and wellbeing. Key sub themes of significance for these students were healthy food, exercise facilities, a supportive curriculum, and access to health services. Many students were aware of the health impact, which their diet could have, however this was overridden by other factors. Financial pressures that students now face have impacted upon their choice of food

and their ability to eat a healthy diet (Sodexo 2014). The main issue for students in paper 7 was not their ability to choose healthy foods but, the cost and availability of healthy foods on campus. Within the undergraduate population specifically, providing information, which is directly relevant to their lifestyle, is effective (Pires et al 2008). Healthy universities can target students, who recognise the need to change their diet, by providing information on how to prepare healthier food quickly and cheaply.

Health to university students in paper 7 is related to exercise and a healthy university setting would enable access to exercise and gym facilities. Many students find difficulties in continuing to practice some form of exercise or sport when they go to university due to the presence, or absence, of quality physical sports provision offered by universities (Gómez-López et al 2010). Not all students in paper 7 had previously practiced sports or exercise programmes. They did however; appreciate benefits to their health and wellbeing from being able to use exercise as a means of socializing with peers. A healthy university would need to consider its responsibilities in adapting and providing sports facilities to promote active lifestyles for all students. It would need to take into account internal barriers that university student's face such as proximity and cost of sports facilities (Reed et al 2005, Reed 2007).

Health for students in paper 7 was characterised as being physically healthy and this they believed should be supported by easy access to health services. A healthy university would, they suggest, have these on site or, in close proximity and be tailored to the student needs. The physical and mental health needs of university students are complex and comprise a wide range of aspects (Mikolajczyk et al 2008, El Ansari 2010). Despite raised health awareness amongst university students; their use of health services is reported as relatively low across universities in the UK (El Ansari 2011). A healthy university needs to undertake health profiles, to meet the specific health and wellbeing needs of their own student population, in order to provide valid health promotion programmes within the university. A supportive curriculum, which promotes student health through its content, would be an additional means of improving student health and wellbeing in the short and long term.

Summary

Encouraging universities to become healthier settings is gaining impetus at regional, national and international levels. The ideology of a healthy university meets higher education institution priorities, for example in the context of both papers in this section that of, the student experience. It also parallels major Government agendas on population health, young people and health, obesity, health related behaviours, climate and environmental issues (DoH 2007, 2008). Going to university is a transitional period that offers many good conditions for the acquisition of healthy lifestyles (Wang 2009) and students come to university with a set of values that are important to them, their health and their academic performance. The two papers in this chapter highlight future issues for consideration for both developing healthy universities, and the UK Healthy Universities network. The settings approach to health, and in particular healthy universities, has been subject to a degree of conceptual development and the model portrayed in figure 4, offers universities some guidance. The concept of healthy universities that can tailor their facilities and supportive environments to one that understand the complex health beliefs and needs, of its own students will go some way to developing students, who are more likely to value and prioritise their health in the short and longer term, through to their adult lives. One of the difficulties is that there is a lack of an explicit theoretical framework to guide policy, practice, and research in this area. Universities and the UK Healthy Universities Network will now need to look to the future as universities develop themselves as settings for health and wellbeing. It will need to look more closely to what their students want from their whole university experience. At the time of writing this commentary I have begun working on a small project to look at how the Self-Review tool, developed by the UK Healthy Universities Network, has supported universities undertaking the journey towards becoming, a healthy university. This and future research is now needed in order to develop a more explicit conceptual framework for future policy, practice and research in this area. Pages 131-145 inclusive are papers 6 and 7.

Paper 6: Holt M (2012) The debt crisis: Tackling gambling related harm to students in higher education. *Health and Social Care Education*. Vol 1(1) pp14-16.

Paper 7: Holt M, Monk R, Powell S, Dooris M (2015) Student Perceptions of a Healthy University. *Health Education* (in Press <http://dx.doi.org/10.1016/j.puhe.2015.03.020>)

Chapter 6: Understanding Health in the Workplace

Introduction

As my role as Principal Lecturer in Public Health developed, my skills in working across different settings to understand health was expanding. This resulted in me taking the lead investigator role for a number of projects. This chapter will draw upon my experience as lead investigator of a commissioned project to understand health within the workplace. I had previously taken the lead in a commissioned project, which explored the relationship between the resilience of Small, Medium Enterprises (SMEs) in times of slow economic growth, and its influence on staff health and wellbeing (Powell and Holt et al 2011 not included in this thesis). Because of our findings in relation to health in this work, we were beginning to develop a 'presence' in terms of workplace health, at meetings, conferences and other formal and informal sessions around health in the workplace. This resulted in being commissioned to lead and undertake a larger piece of work, which specifically explored health and wellbeing in SMEs. This paper will be discussed in this chapter and will be supported by a commentary and relevant literature.

Introduction to paper 8:

Holt M, Powell S (2013) Health and wellbeing in small medium enterprises (SMEs). What public health support do SMEs really need? *Perspectives in Public Health. Journal for the Royal Society in Public Health*. 135: pp49-55,

This paper was written as a result of a piece of commissioned work which examined the health and wellbeing needs in small and medium sized enterprises (SMEs) across Greater Manchester, and the support that public health professionals can offer. Using convenience and opportunistic sampling methods, the study adopted a Health Needs Assessment (HNA) approach (see Figure 6):

HNA starts with a population – when the health needs of that population are known proposals are put forward for the development and delivery of improved programmes and services (NICE 2008 p 17).

The SMEs who participated varied in size and type of business, and were categorised as (Retail, Manufacture, Legal, Finance).

Previous commissioned work we had undertaken with SMEs exploring health and resilience in SMEs, had enabled us to appreciate that SMEs are notoriously difficult to access (Powell and Holt et al 2011). We found that simple, short telephone interviews worked for us in gaining a participating sample and we used this approach for this published study.

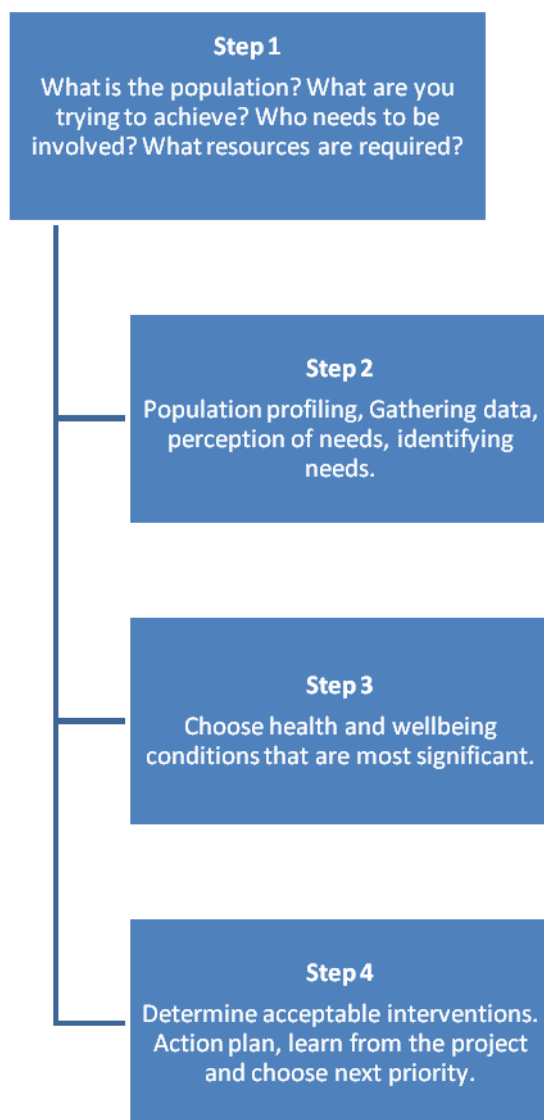


Figure 6: Health Needs Assessment (NICE 2008) Adapted.

From the potential 1500+, SMEs in Greater Manchester the research team (2 interviewers) undertook 91 telephone interviews. All telephone interviews were carried out with SME owner/managers. In all cases, those that did participate did so immediately, as time constraints were a key issue and it was necessary to keep the interview time to around 5-10 minutes. Semi-structured questions were used to collect the data to identify the health and well-being needs of the sample of SMEs in Greater Manchester.

Data were analysed using thematic analysis by identifying repeated patterns and themes within the data (Braun and Clarke 2006). This was a small study and whilst not being generalisable is similar to other small studies in being useful for gaining information from specific groups and subgroups in a population (Creswell 2009). We used the needs assessment framework in Figure 6, which we adapted to suit our purpose. It acted as a logical means of guiding the whole project. It also helped us to present a clear process and logical argument for findings to public health colleagues and other organisations that we were requested to present to, such as the North West Health at Work Workforce Development Group. Such groups constitute members from a variety of workplaces (for example Banks, hotels, shops, Industry and Unions).

Key Themes

The North West has discernible health inequalities attributed to levels of economic activity and sickness absence in the region is amongst the highest in the country (Sedgley and Dooris 2007). This illustrates the specific challenges that the North West faces and why work is an important issue for the public health workforce in the region (DoH 2004). Health professionals need not only to be concerned with whether the working age population are in jobs, but also the extent to which work, and the workplace, affects health and wellbeing outcomes (Coats and Lekhi 2008). Two key themes emerged from the study we discuss in paper 8. Acute seasonal sickness was the most pressing reason for employee absence from work (viruses, flu, seasonal disorders) for the SMEs in this research. This accumulated to the theme of sickness presenteeism. This research highlighted that employees will present at work with acute illness. This type of illness requires rest, is easily transmitted to other employees

and takes longer time to recover from due to cross infection and re-infection occurring. A subsidiary theme was that of authenticity and the reporting of sickness, contributing further to sickness presenteeism as employees seek to legitimise their illness. The study concluded that for these SMEs in Greater Manchester Public Health preventative services such as the provision of flu vaccines might be one way, of supporting SMEs with acute seasonal episodes of illness.

Workplaces as settings for promoting health and wellbeing

Health and wellbeing in the workplace is a concept, which provides a fundamental business case for a productive, happy and healthy workforce. In his report on public health Wanless (2004 p162) stated:

Employers have much to gain from considering the revenue implications of preventative health for their business.

He concluded that companies in both private and public sectors could benefit greatly from investing in their employee health and wellbeing; in particular preventing ill health and disease. The argument for engaging in staff health and wellbeing, fostering both improvements in staff turnover and workplace absence, is supported further by Shain and Kramer (2004). They offer a useful diagram, which indicates the forces that act on health and productivity in the workplace (see Figure 7). Their point being that the responsibility for employee health is considered as one, which is a shared responsibility between employer and employee. Such diagrams are a useful for identifying antecedents to the effects on health in the workplace, and for optimising workplace areas for action and intervention, to improve health and wellbeing.

Dame Carol Black's (2008) review of the health of Britain's working age population estimated an annual economic cost of ill health in terms of working days lost and worklessness to be over £100 billion. The review concluded that:

Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice (Black 2008 p9).

The key objectives derived from Black's (2008) review are on prevention of illness and the promotion of health and wellbeing. This very much correlates with those needs identified in paper 8 with a strong focus on prevention and protection. For those who develop a health condition Black (2008) outlines the need for early intervention and an improvement for those unemployed so that they have the potential to work. The Government's response in "*Improving Health and Work: Changing Lives*" (DoH 2008) suggests a range of initiatives built around three goals; creating new perspectives on health and work, improving work and workplaces and supporting people to work.

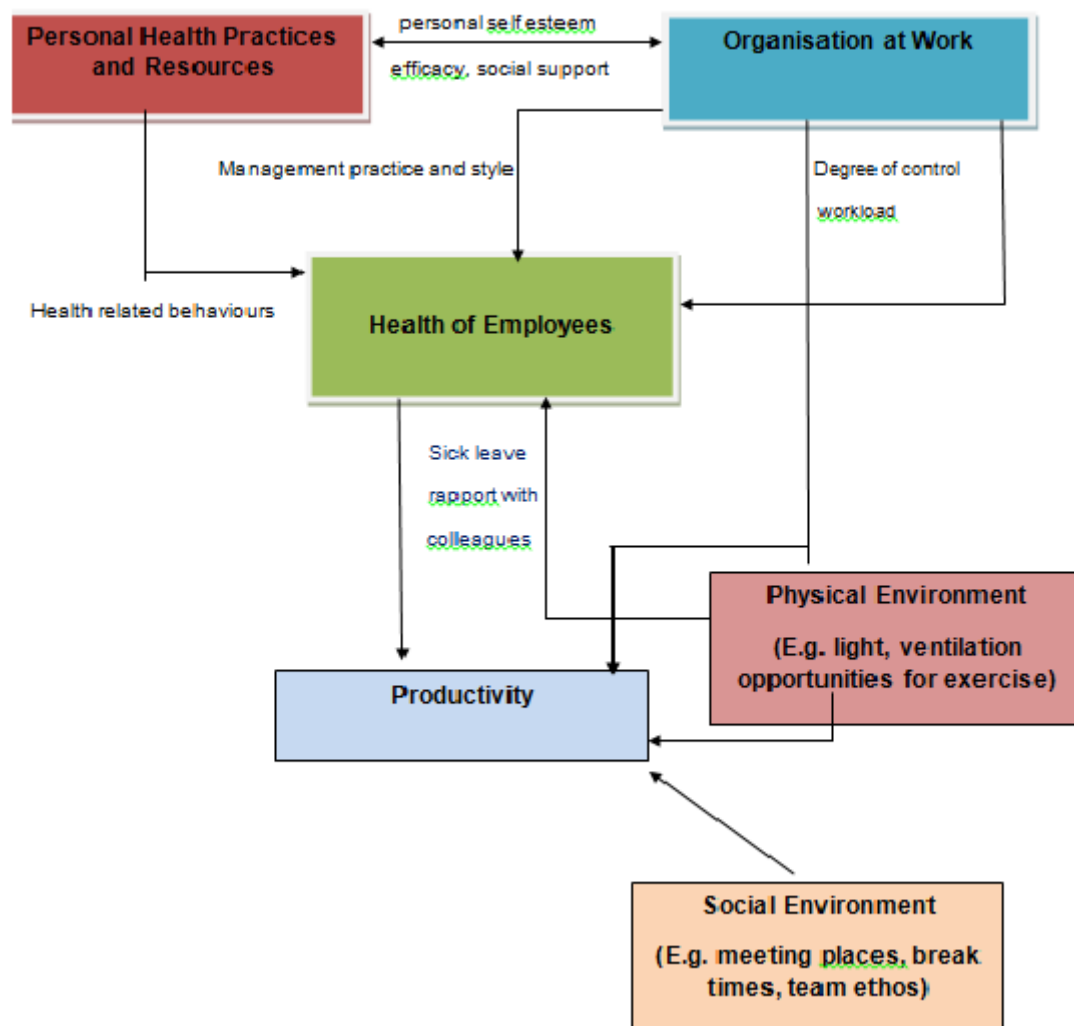


Figure 7: The Relationship between Health and Productivity in the Workplace (Shain and Kramer 2004)

Workplaces as Healthy Settings

The ideology of the health promoting workplace is fairly new and is underpinned by the WHO (1986, 2005) concept of the settings approach. Taking a settings approach to understanding health in the workplace fosters a concern for placing health and wellbeing into the very constitution of an organisation, ensuring that the everyday activities of the organisation are committed to health and wellbeing. It focuses on the many varied intervention points along a continuum, which includes:

- Improving access to work for socially and economically excluded groups
- Ensuring provision of a safe and fulfilling working environment
- Reducing the ill-effects of work on the health, well-being and quality of life of individuals, families and communities
- Utilising the workplace as a setting to promote good health
- Increasing the positive impact and decreasing the negative impact of workplaces on the health of the communities in which they are placed and on the health of society and the environment more generally (Dooris 2004).

There is then, a fundamental difference in carrying out health education within a setting, to that of a setting for health and wellbeing (Dooris 2004). Paper 8, would resonate with a narrower view of health education and intervention within the workplace setting, and the kinds of workplace interventions suggested in frameworks such as in Figure 6. Drawing from Dooris (2004) who suggests an intervention point using the workplace as a setting to promote good health. Workplace health promotion includes a wide range of activities and measures, with outcomes at individual and organisational levels (Sedgley and Dooris 2007). A review by Kreis and Bödeker (2004) concluded that such programmes could have a positive impact on the workforce. Furthermore, whilst interventions which address the workplace organisations and culture as a whole are not common, those that are, show that they are effective (Naidoo and Wills 2009).

Understanding Health in SMEs

Research into small, medium sized enterprises (SMEs) and workplace health promotion (WHP) is limited. Those studies undertaken have highlighted that SMEs mainly adopt preventative approaches to WHP addressing risk factors, rather than the wider concept of the organisation and environment (Hasle et al 2006). Furthermore,

evidence from a joint survey by the Advisory, Conciliation and Arbitration Service (ACAS) and The Chartered Institute of Personnel and Development (CIPD), suggests that both employers and managers in SMEs are dealing with a complex range of needs in order to manage health and wellbeing in the recession (ACAS and CIPD 2009). In the context of our study, it is also recognised that employers themselves are under significant pressures to make cost savings (ACAS and CIPD 2009). As a result, SMEs may not be in a position either to invest in occupational health services or access available services. The disparity between larger employees and SMEs is unsurprising as SMEs, in particular smaller and micro organisations often lack the dedicated resources and expertise to design and organise, health promotion programmes in the workplace (McMahan et al 2001). They further add that health and safety regulations can overwhelm SMEs acting as a barrier to other health promotion programmes that are not mandated by law.

There is increasing attention being focused on the ideology of work-life balance, with the espoused benefits including improved retention rates and increased productivity. However, much of the discourse is founded on traditional models of large organisations. These traditional boundaries are often blurred when looking at SMEs. This is because often within SMEs, work-life balance and health and wellbeing policies are informal and individually negotiated. In the case of small and micro sized employers, they are considered as being too expensive (Department of Labour 2004). An additional problem is the variability and differing size of SMEs. Some are owner-manager or family owned which result in issues such as higher levels of job demand, longer working hours and less time for leisure activities (Chua et al 2004).

It is well documented that sickness absence in the workplace is accepted as a significant problem, resulting in a major impact on employers, employees and the quality of service provided by an organisation. Sickness absence data are considered a useful indicator of the health and wellbeing of the working population (DoH 2004). Boorman's (2009) review on the health and wellbeing of staff within the NHS, revealed a considerable economic burden and a recognition of the benefits to both individuals and employers, associated with a healthy and contented workforce. Whilst the NHS is a significantly large employer, many of the Boorman (2009) recommendations are applicable to other private and public sector organisations,

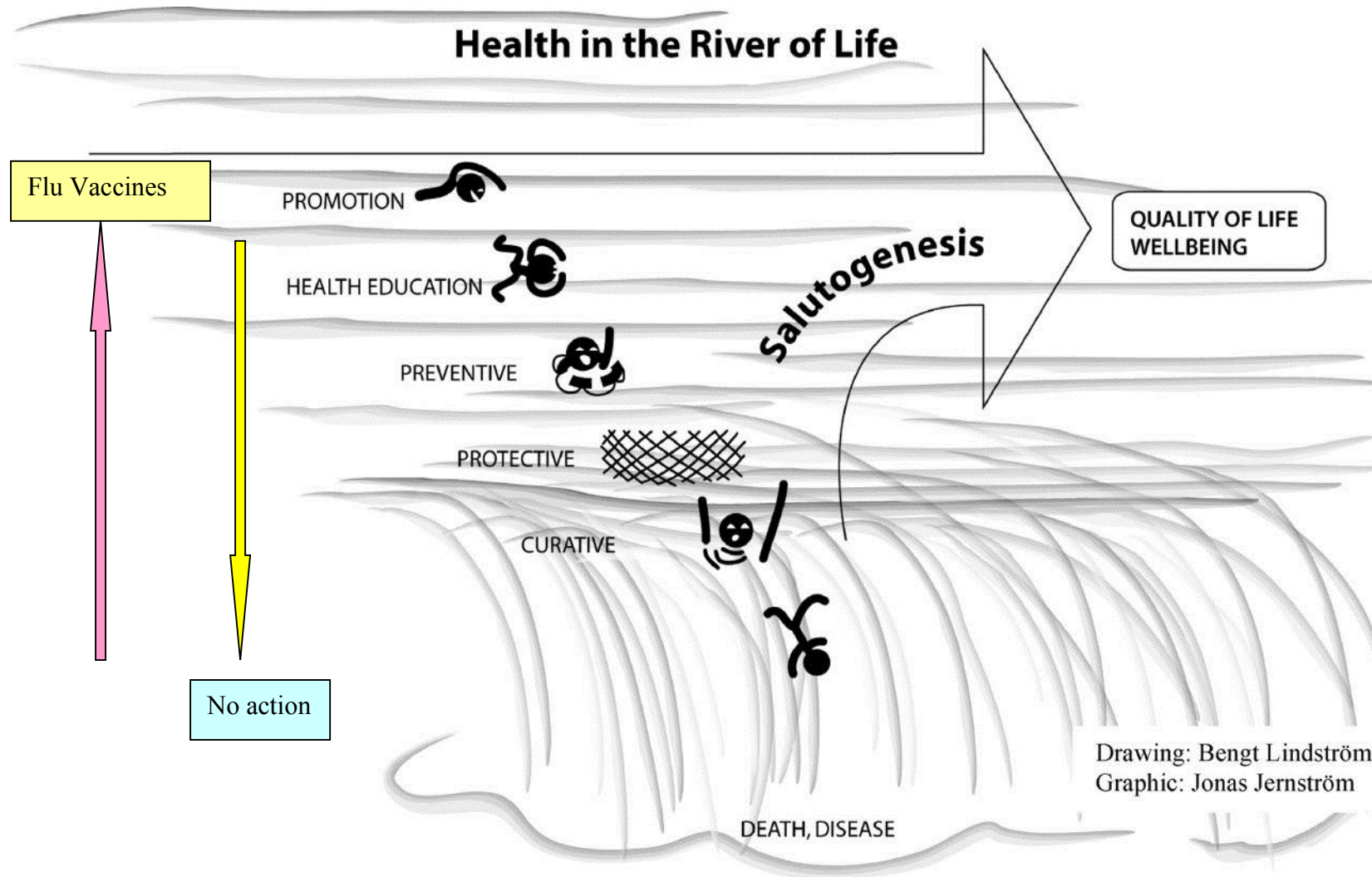
including SMEs. However, it is also recognised that SMEs in addition to less opportunities to access occupational health services, have less opportunity to respond to some of the recommendations that services may make due to the lack of capacity in their organisation. In the current economic situation, SMEs, due to their size and direct and indirect costs, cannot afford to lose their labour force for significant periods. This was abundantly clear in the work we did for paper 8. The issue of absenteeism is significant for both large and SMEs. However, it is suggested that absenteeism costs are generally higher for larger organisations (Kelloway and Cooper 2011). Alternatively, the need to re-organise workloads due to sickness absence can actually present more of a problem for SMEs due to lower employee numbers. This can result in presenteeism in SMEs where both manager/owners and employees, continue to work despite suffering poor health. Both these factors were evident in our study as reported in paper 8. The cost of presenteeism is largely invisible and far more difficult to calculate, than that of the cost of days lost in work (Hemp 2004). Furthermore, presenteeism is considered a much costlier problem than its productivity-reducing counterpart, absenteeism (Hemp 2004). The implications of presenteeism replacing absenteeism are much broader, as those factors which have traditionally been linked to absenteeism could very much now, be linked to presenteeism.

The settings approach to understanding and promoting health is underpinned by an ecological model, which understands health as being determined by a complex range of factors. This reflects the changing focus from pathogenesis (cause or development of a disease) to salutogenesis (focuses on how to interpret and explore health in a positive sense, philosophically described as holism). Alternatively, as Antonovsky (1996) asks ‘what causes health’? The river metaphor of health development (see Figure 8) has been used to illustrate that rather than keep people from falling in the river, they have to learn to swim (Antonovsky 1987, Erikson 2008). The curative or treatment perspective of health is the analogy of saving people from drowning by using intervention(s). Upstream approaches would offer support at an earlier stage. Health protection and prevention is the protective or limitation aspect of disease. Its purpose is:

To reduce the negative effects and risks thus maintaining the health of the public. The interventions are both population-directed (protective) and individual-based (preventive) (Eriksson and Lindström 2008).

The next stage is the input of health education and health promotion. The deficit perspective from the point of view as to what works to improve health and eliminate disease has been agreed as having many shortcomings (Morgan and Ziglio 2010, Eriksson and Lindström 2008). It is also proposed that the pathogenic paradigm is misleading by suggesting that we can eliminate risks and subsequent disease, thereby resulting in health (Antonovsky 1987). This has led to what Dubos (1961) argues, has been the driving force behind the 'quick fix' approach to eradicate disease, which focuses on individuals and is met with criticism (Hunter 2008). Despite such criticism in the context of understanding health within the workplace project discussed in paper 8, health was perceived in such biomedical terms with the quick fix approach identified as a predominant need. Figure 8 is used in this context to illustrate how flu vaccines as a quick fix approach may prevent people from keep falling in the river.

Figure 8: Health In The River of Life (Eriksson and Lindström 2008)



SMEs face considerable challenges in the current economic climate (Black 2008, Boorman 2009). These challenges can mean they fail to appreciate the wealth of health and wellbeing programmes that are already available to them. What we found was that these programmes did not necessarily meet the health needs of those SMEs in our study. Downstream action in this context would be to ignore this finding. Whilst the theory of Salutogenesis justifies a degree of deviation from the preventative biomedical model of health, the pathogenic paradigm of biomedicine has a role to play. In the context of the study discussed in paper 8 a 'quick fix' approach to preventing ill health and health protection, is what the SMEs identified as being their predominant need.

Summary

Working age adults spend a significant portion of their lives at work. Workplaces therefore offer a prime setting for understanding and supporting health, by creating workplace environments where the opportunities and practice of positive health is easy, and endorsed by the organisation. Paper 8 explored the health and wellbeing needs of a sample of SMEs in Greater Manchester. This study helped us to understand what health may mean to such workplaces. It highlights that smaller, and in particular micro businesses, feel the effects of sickness, presenteeism and sickness absence more acutely, than medium sized businesses. This is significant for those in public health and those other organisations that seek to support SMEs through these economic challenges. The recommendations made from the study in paper 8 may potentially influence the management of sickness, sickness absence for acute illness, presenteeism and subsequently productivity for smaller and micro businesses. Whilst the focus of salutogenesis is that of positive health and wellbeing at the same time, it is possible that it can be a conventional way of achieving preventative health goals. It is sensible and economical therefore for workplaces to adopt programmes that will prevent acute episodes of disease. We were invited to present the findings from this study to those who lead in public health at a local and international level. This identified that more research is needed to better understand how best practices can be translated, and successfully adapted for small and medium sized enterprises. Pages 157-165 are paper 8.

Paper 8: Holt M, Powell S (2014) Health and wellbeing in small medium enterprises (SME). What public health support do SMEs really need? *Perspectives in Public Health. Journal for the Royal Society in Public Health.*

Chapter 7: Reflections and Conclusions

This thesis has presented eight published papers and two book chapters as a collection of work linked by the need to better understand health across different settings and contexts. Denzin and Lincoln (2005) propose that a goal of qualitative inquiry is to understand human experiences, how these experiences are socially constructed and how individuals acquire meaning from these experiences. The collection of work in this thesis has provided me with greater insight into the variations of health and people's own views and expectations of health in different settings and contexts. When presenting the findings of our study discussed in paper 8 to a group of senior managers from SMEs, I was asked why I introduce myself as Principal Lecturer and, a nurse. My professional journey began as a nurse and it is this professional background, which underpins my values and principles, in addition to my background knowledge and skills. I reflect then, that whilst I now apply my knowledge and skills to different contexts through research and knowledge exchange work, the nurse is still in me. It is this professional role, which underpins this thesis, and more significantly will help me to help others, in particular nurses, to come to a better understanding of health.

I began my academic journey writing about my work into helping student nurses understand their role in promoting positive health, with their patients. Through papers 1-5, I can recall my academic interest and profound professional belief in placing the role of promoting positive health at the core of the nursing curriculum. Consistent feedback from my own students, which is discussed in papers 1-5, suggested that there was a problem with the uptake of this role by nurses. Nurses look to an array of models and definitions to guide practice, and the World Health Organisation's (WHO 1946) definition of health has become a mantra for teaching nursing students (and others) what health may mean to their patients. This definition is frequently cited within nursing and health promotion literature. My own current role involves little classroom teaching and so, I was excited to be asked recently to teach a session on the concepts of promoting good health to a group of year 2, undergraduate nursing students. Like all tutors before me, my opening speech began with the need to firstly understand health. I was however, quickly interrupted and assured by the students that they understood health. Moreover, to prove this they confidently and accurately

recited the WHO (1946) definition of health. I was not entirely convinced that the students did understand health simply because they could recite parrot fashion a learned definition. When asked for examples in relation to practice they conceptualised health as an absence of disease, with the objective criteria being that of diagnosis and treatment. The criticisms of nursing's contribution to understanding health, and in particular the promotion of health, are drawn upon in papers 1-5 in this thesis from both others and my own work. It would seem that from those who have cited the work in this thesis, and others that have more recently explored this area of nurse's work, there is still a problem (see for example Kemppainen et al 2012) who suggest that:

More research is needed to determine how to support nurses in implementing health promotion in their roles in a variety of health-care services (p10).

The concept of health is a basic building block for nursing theory. How health is defined dictates how nurses are educated and how they should practice. Thinking back to the recent teaching session, I ponder then whether nurses simply follow the script that they learn in their nursing education. This then defines their understanding of health and their role in promoting health. Pender (1996) proposes that health is a subjective experience, which becomes fragmented in the minds of health professionals in general. Furthermore, nursing care plans and assessments are usually lacking a coherent view of health (Furber 2000, Cross 2005, Irvine 2007). This would question the concept of a holistic view of health within nursing; in particular, as such requisites underpin the successful promotion of good health (Tones 2001, Seedhouse 2004). I reflected upon this as I considered the collection of papers within this thesis, and through them the differing understandings of health that I had come to appreciate. I also reflected upon the changing nature of nursing in the 21st century and the requirements of those who teach nurses. Contemporary undergraduate nurse education certainly champions the role of the nurse in health improvement, and models such as RCN (2012) (Figure 2) offer a broad scope for nurses across all disciplines to do this.

The papers within this thesis have highlighted a range of meanings and understandings of health to people in different settings. Health for students in

universities within papers 6 and 7 reflect the more physical aspects of health and the need for supportive environments to create this, such as healthy universities. Health in SMEs discussed in paper 8 was expressed in biomedical terms as *merely the absence of disease* and the remedy as being, a quick fix approach, which receives much criticism and debate as to its usefulness. These expressions of health need would tend to somewhat contradict holistic models of health so diligently taught in nurse curricula. Reports such as Darzi (2008) reflect the need for prevention rather than cure. Alternatively, there is also still the demand for cure and treatment and one can easily understand why nurses are caught in the crossfire of trying to balance competing approaches in understanding and helping patients towards positive health.

The Standards of Proficiency for Pre-registration Nursing Education (NMC 2010) guide universities on the structure and nature of the nursing programme. How universities choose to interpret this in terms of their curriculum content and delivery modes varies considerably. These educational programmes ensure that the students acknowledge and understand the profession (Karaoz 2004 p129). Therefore, improving and developing the profession relies upon students who leave their initial training and enter the world of qualified practice, with sound epistemological (knowledge), ontological (being) perspectives and clear conceptualisation of its values (axiology). In an effort to enable nurses to engage with the ethos of an ever-evolving healthcare setting, nurse educationalists are striving to meet the demands of NHS reforms, through developing and re-developing the nursing curricula. The Chief Nursing Officer for England's report *Modernising Nursing Careers* (DoH 2006), highlighted the need to prepare future nurses who can work across a range of settings and, be more responsive to people's needs and expectations. Thorne (2006) deliberates the changing context of a health care service in meeting the ever-changing needs of the people it serves. She proposes that this will require nurses who are able to deconstruct ideologies and, consider alternative ways of understanding the world.

Finding an Alternative Way of Understanding

I wonder then, in the context of this thesis, what that alternative way of understanding the world of health may be. The published papers in this thesis have taken me on an interesting and enlightening journey, to explore and better understand health for

people across different settings and contexts. Having reached the end of this particular journey, I contemplate how my experiences and increased knowledge may be used. Papers 1-5, suggests that there is a problem with nurses getting to grips with understanding and practicing their role in the promotion of positive health. Citations of these papers and more recent research are still asking the same questions and still wondering if there is perhaps, another way. I considered my recent teaching session and how, the nursing students were firm in their beliefs about understanding health. Yet there was no evidence in that session that they really did. Herein lies the problem. The WHO definition of health cited in contemporary nursing literature, and the one described to me by the students, is used as a framework for promoting health (Tones and Green 2004) but, this can bring with it unrealistic expected outcomes. Seedhouse (2004) goes further to suggest that the definition should be removed from the literature. This argument of course may be challenged as the definition whilst having limitations, has been used in significant research in health care. Definitions of health used by nurses as a guideline to practice, suffer from limitations as they fail to draw a coherent picture about the real meaning of health, to people. Nurses must learn how to assess, utilise, and manage knowledge, rather than trying to pack thousands of facts into their heads, hoping to be able to retrieve them when needed. Therefore, nurses need to examine how health for individuals is specifically expressed and met in different contexts and settings, rather than exclusively practicing within a context of pre-established models and definitions. Having journeyed through the different understanding and expressions of health for people within the papers in this thesis, I return to the undergraduate nurse curricula and the need to consider what and how we teach and enable nurses to understand health. Nursing students are well educated and versed in the classic definitions of health yet, there is in fact still no one correct definition of health and increasing attempts to define health are as Seedhouse (2004) proposes an 'unfruitful exercise'. Some used in nurse education are at odds with nurses' conceptualisation of 'holism' that leads to individualistic, victim blaming, 'lifestyle' approaches to understanding health. My narrative at the start of this thesis reminisced my own training and development as a nurse and I am not suggesting that we hanker after a system where authoritarian nursing sisters were feared. The world has changed and so has the job of nursing. However, the process of parrot fashion learning about health for people will not prepare nurses for a changing world.

Antonovsky's (1996) idea of salutogenesis is that it is an alternative way of seeing the world. He argued that health is not a 'state' as provided by the WHO (1946) and a concept of health used in nurse education. Rather, it is how people interact with their resources and conditions of the living contexts. I have chosen to use the concept of the settings approach to understanding health to draw the papers in this thesis together. It seemed to me a logical way of coming to understand health for people in their everyday settings and lives. The concept of settings is underpinned by a shift from causes of illness to that of what causes health (salutogenesis). This exploration of how people stay well or, what creates health (rather than ill health) in a setting may be a more salient way for nurses to understand health. Developing the nursing curricula (and indeed any other health curricula) to understand health through a settings theory lens; i.e. what cause health (as opposed to ill health) for that person in that setting, may offer nurses a better understanding of people's real experiences of health.

The influence that specific areas or environments have, on nursing students experience in terms of career intentions is well documented (Clare et al 2002, Edwards et al 2004). More recently, it is suggested that English nurse education and preparation is:

Still heavily centred in secondary care settings, particularly in relation to clinical practice experience (Betony 2012 p21).

Project 2000 (UKCC 1986) whilst short lived, did result in the "Making a Difference" diploma and degree nurse preparation programmes (DoH 1999) which, maintained some of the key components of Project 2000. For example:

There was a greater emphasis on concepts of wellness and health, linked in part, to the health policy that recognised that care would increasingly take place in primary rather than secondary care settings (Betony 2012 p22).

It is further suggested that more research into supporting nurses implement positive health across a variety of health services is needed (Kemppainen et al 2012). Yet this

in itself is limiting if we only look to health services. For example, a university may not be considered a place where nurses undertake clinical practice or, undertake work to influence the health of people in its setting. Yet, nurses do their academic training within a university setting and therefore such a setting may be considered one where nurses learn about health and how to promote positive health. It is also a setting where nurses can disseminate this to a wider audience. Whitehead (2011) suggests that there are few examples of nurse led health initiatives in a university setting. As previously indicated, one of my roles within the university is to co-ordinate the Healthy Universities Initiative. Taking a whole systems approach to health and wellbeing within my own organisation (Figure 5), has enabled me to look at how we can use the university setting to give our own nursing (and other) students experience in leading on health initiatives and research, within the organisation and its local community. These include exploring and understanding what health may be to the students and staff within the university setting and developing in-house initiatives to address these needs. We do this by offering in effect, our own in-house clinical placements for the nursing students who claim practice hours towards their training. However, more importantly the students begin to understand how health occurs across different settings. Whitehead (2011) offers a useful framework for considering health and its promotion across a lifespan setting continuum (Figure 9). The diagram illustrates the various proposed settings that a person may be likely to experience as a 'right of passage' (Whitehead 2011) through the lifespan. On the periphery, there are settings that may not necessarily form the normal order of the majority of an individual's life health journey. This diagram can be used to illustrate the different types of settings that nurses may work in. More importantly in the context of this thesis, it illustrates the stages of lifespan in each of these settings where nurses may take a salutogenic approach to explore what creates health at each of these stages.

Health care environments remain the mainstay of clinical learning for nursing students, yet health care environments are not the context in which people engage in their daily lives. Health care restructuring and cuts to community health programs, along with increased enrolments in nurse education programmes, have made the allocation of clinical placements for undergraduate nursing students extremely challenging for universities. Undergraduate nursing curricula, which use a settings approach to understanding health, would enable nurses to experience what creates

health for people in different settings. This would mean incorporating the use of non-traditional settings (e.g. the workplace, universities), for nursing placement experiences in exploring health for people in their real lives. As I finish writing this last chapter two significant policy documents have emerged and, one is in the process of development and I have been actively involved in two of these. Firstly, Lord Willis' (HEE 2015) report on the review of nurse education has emerged. The report proposes that nurse education programmes in the future, should enable nursing students to have the skills and knowledge to work across a variety of settings, to cross professional boundaries, and to improve practice experiences. Interestingly, his report calls for nursing to *seize the moment* for nursing to drive innovation and change (HEE 2015). This is no easy task as it means considering both the content of the undergraduate nursing curricula, in addition to how this is translated into practice. This will have also implications for mentorship and assessment in practice.

Secondly, Whitehead (2011) has proposed little use of universities as places where nurses actively become involved in health initiatives. This thesis has discussed the role of universities as settings for health and more significantly, a place where nurses study their profession and the contributions they can make to the improvement of health. The ideology of Healthy Universities whilst underpinned by the Ottawa Charter (1986) settings concept has lacked a sound evidence base particularly in terms of evaluation (Dooris 2004). Indeed, one of the criticism of the Ottawa Charter (1986), whilst being the fulcrum for the settings approach to health, is that of its lack of guidance on evaluation methods for health promotion (Hans 2007).

Notwithstanding this, it is still cited in contemporary public health policy. In particular those that have influenced Healthy Universities developments. In July this year, I presented three papers, two from this thesis, at the international conference on healthy universities in British Columbia. More significantly, this conference was to review previous policy on healthy universities, in particular the Edmonton Charter for Health Promoting Universities and Institutions of Higher Education (2005). The results of the conference and workshops we carried out are the new Okanagan Charter for Health Promoting Universities and Colleges (Oct 2015). A document that again draws on the Ottawa Charter (1986) but offers clear calls to action for HEIs to develop themselves as healthy settings. A document that offers guidance as to the why, and more importantly the how, to do this. Finally, I have very recently become

part of a Health Education England working group to develop a framework for best practice in developing public health, within all undergraduate health curricula. One key area for consideration within the framework is that of health curricula to include an understanding of health across settings.

I reflect back upon this thesis and how through its journey, public health and all that it entails in the context of this thesis, has seemed at times to take centre stage in policy development. However, the latter part of my discussion here ignites some hope in me that it really has and that we really are ready now to seize the moment! By taking the settings approach to understanding health and the creation of health (as opposed to ill health), people's experiences of health and the promotion of positive health, would mean that future nurses may well be equipped to meet the changing needs of people, work across a range of settings, and understand and respond better to people's health and expectations.



Fig 9 The Lifespan Setting Continuum (Whitehead 2011)

Final Thoughts

One of my academic colleagues, having very recently returned from a national nursing conference, stopped me on the corridor and said (tongue in cheek) ‘do you know that nurses are at the forefront of promoting positive health?’ I understood and appreciated the irony, but found it disappointing and somewhat frustrating, that the questions and criticisms of nursing and its contribution to health and the promotion of health I began asking in paper 1, are still being asked now in 2015. The published works presented here are wide ranging in their format and cited by other authors, both internationally and nationally. The work that contributed to them has enabled me to propose changes to the undergraduate nursing curriculum and, practice experiences for students using a settings concept to understand health.

Historically, the PhD credits the written word; however, I note that it is only one form of philosophical and academic communication, representing only the most perceptible trace of the development and dissemination of ideas. I have taken a journey approach to the development of this thesis and have demonstrated this diagrammatically as a timeline (Figure 1). Whilst I offer my contribution to nursing knowledge, my journey has contributed to so much more. In addition to writing this thesis, its findings, and contents of the published works have been shared through practitioner publications, national and international conferences, presentations, reports, meetings, classroom teaching, curriculum development, and work for Central Government and currently Health Education England, in developing nursing Public Health competencies. In addition, I have contributed to workplace health and wellbeing knowledge and national and international work on Healthy Universities. Therefore, through my writing, I have contributed to wider existing evidence and have actively helped to shape an emerging network of understanding about health in different contexts and settings, and would suggest that these are also my additional contributions to knowledge. My professional roots as a nurse have always been at the heart of this thesis despite diversifying my roles over the past few years. I began this journey looking at how nurses can and should, promote health. The journey took me to a conceptual realisation that to truly promote positive health we must first enable nurses to understand the realities of what creates health, for the people we work with and care for. The papers presented here and the contribution of the work that enabled their

development, offer me an opportunity to propose an alternative way of helping nurses and others understand health in the real world of people and their everyday settings.

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- Whitehead D (2004) Health promotion and health education: advancing the concepts. *Journal of Advanced Nursing* 47(3), pp311–320.
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Appendix 1: Contribution To Publication Forms

Research and Knowledge Exchange		 Manchester Metropolitan University
Graduate School		
Form RDPUB (ROUTE 1 AND 2)		

PhD BY PUBLISHED WORK (ROUTE 1/2): CONTRIBUTION TO PUBLICATIONS

This form is to accompany an application for registration for PhD where the PhD is by Published Work. A separate form should be completed for each publication that is submitted with the proposal and should accompany the RD1 form.


1. The Candidate		
First Name(s):	Maxine	Preferred Title: Mrs
Surname:	Holt	
MMU e-mail address:	m.holt@mmu.ac.uk	Contact Number: 2472240
Personal e-mail address:	m.holt@mmu.ac.uk	Student ID Number: 6871453X
2. Title of PhD Proposal		
Helping People Understand Health Across Different Settings		
3. Title of Research Output		
Holt M, Warne T (2007) The educational and practice tensions in preparing pre-registration nurses to become future health promoters: a small scale explorative study. Nurse Education in Practice. Vol 7 (6) pp 373-380.		
4. Candidate's contribution to the research output (State nature and approximate percentage contribution of each author)		
Maxine Holt (75%) was lead author with data from MPhil Tony Warne (25%) was co-author		
5. Co author(s):		
I confirm that the contribution indicated above is an accurate assessment of the contribution by the candidate to the research output named in section 3.		
Name	Signature	Current e-mail address
6. Statement by Director of Studies/Advisor		
I confirm that I have read the above publication and am satisfied that the extent and nature of the candidate's contribution is as indicated in section 4 above.		
Signature: _____		Date: _____
(Director of Studies/Advisor)		
7. Signature of Faculty Research Degrees Administrator		
Signature: _____		Date: _____
(Faculty Research Degrees Administrator)		

Research and Knowledge Exchange		 Manchester Metropolitan University
Graduate School		
Form RDPUB (ROUTE 1 AND 2)		

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2. Title of PhD Proposal		
Helping People Understand Health Across Different Settings		
3. Title of Research Output		
McCarthy J, Holt M (2007) Complexities of policy-driven pre-registration nursing curricula. Nursing Standard. Vol 22 (10) pp35-38.		
4. Candidate's contribution to the research output (State nature and approximate percentage contribution of each author)		
Maxine Holt (50%) Co-author Jill McCarthy (50%) Co-author		
5. Co author(s):		
I confirm that the contribution indicated above is an accurate assessment of the contribution by the candidate to the research output named in section 3.		
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I confirm that I have read the above publication and am satisfied that the extent and nature of the candidate's contribution is as indicated in section 4 above.		
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7. Signature of Faculty Research Degrees Administrator		
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Research and Knowledge Exchange		 Manchester Metropolitan University
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Jack K & Holt M (2008) Community profiling as part of a health needs assessment. Nursing Standard. Vol 22 (18) pp51-56		
4. Candidate's contribution to the research output (State nature and approximate percentage contribution of each author)		
Maxine Holt (50%) Co-Author Kirsten Jack (50%) Co-Author		
5. Co author(s):		
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Holt M (2008) The educational preparation of student nurses as communicators of health and wellbeing. Perspectives in Public Health. Journal for the Royal Society in Public Health Vol 128 (4) pp159-160.		
4. Candidate's contribution to the research output (State nature and approximate percentage contribution of each author)		
Maxine Holt (100%) Author		
5. Co author(s):		
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Holt M, Webb L (2011) 'Engagement, motivation, and changing behaviour' Nursing: Communication Skills in Practice. Oxford University Press		
4. Candidate's contribution to the research output (State nature and approximate percentage contribution of each author)		
Maxine Holt (75%) Author Lucy Webb (25%) Co-author		
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Holt M (2012) The debt crisis: Tackling gambling related harm to students in higher education. Health and Social Care Education. Vol 1(1) pp14-16.		
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Helping People Understand Health Across Different Settings		
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Holt M (2012) Public health and nursing practice: Seizing the receptive moment. Nurse Education In Practice. Vol 11 (4) pp224-227		
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